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THE CRUEL VEGETARIAN*

BY MAJOR HYMAN S. BARAHAL, M. C.†

In recent years there has been a growing popular interest in psychology and human behavior. Various phases of normal and abnormal psychology are taught in our schools, discussed in our homes, and utilized in a practical way in better adjusting ourselves to our environment. Many business establishments have instituted psychiatric departments to aid them in the hiring of employees as well as in handling emotional problems which may arise. There is an earnest attempt being made to understand why we behave as we do, why we display certain personality defects, and why we are subject to marked changes in mood and temperament. We also try to make clearer the reasons for certain unreasonable prejudices and idiosyncrasies which most of us, at one time or another, harbor.

From the modern viewpoint, it is insufficient merely to give a superficial description of someone's personality traits; one must consider in a more dynamic manner the *reasons* for such traits. A number of years ago, for example, we believed that we had a good understanding of a man when we described him as being domineering, fault-finding, suspicious, vain and selfish. Now we want to know the real and unconscious motivations which contribute to his character-formation. In other words, what are the psychological factors which cause him to have this type of personality?

In previous years it was sufficient to classify as a "bad boy" one who was a problem at school, misbehaved, disobeyed his teachers and parents, and was a bully toward the other children. There was only one way of handling such a problem and that was by administering, what were believed to be the "proper" disciplinary measures. There was no concerted attempt made to understand the basic reasons for the child's incorrigibility. At the present time, when a child is difficult to handle we don't merely blame and chastise him, but we endeavor to find out why he behaves in a cer-

*This manuscript was prepared prior to the author's entering military service and contains no material or conclusions gained from experiences in the military service.

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tain manner. We study the child not only as an individual but in its relationship to its parents, siblings, teachers and playmates. We delve into its play-activities, frustrations, emotional attachments and antagonisms, and try to discover what it has to *gain* by being *bad*. In practically every case, if our detective work has been sufficiently thorough, we eventually find the cause or causes for the misbehavior. It is frequently gratifying to observe the improvement which results when the irritating factors in the child's life are alleviated.

Most of us are so constituted emotionally that we both fear and resent a truthful evaluation of ourselves by others. We hate to be told, for instance, that the reason we wear flashy clothes is that we are exhibitionists, and not, as we have always prided ourselves, that we have a better than average appreciation of color combinations.

It is with considerable trepidation, therefore, that we try to unveil the true psychological motive behind the practice of vegetarianism. Should we, perchance, discover that the unconscious basis for this fad is not very flattering to the vanities of its followers, we can only offer as an emollient the fact that we are all subject to certain beliefs and practices throughout our lives which if put to careful psychoanalytical scrutiny would prove to be not very complimentary to us.

As mere human beings we are generally conceded the prerogative of possessing an occasional pet idiosyncracy, a privilege with which we are particularly endowed by our philosophy of "rugged individualism." We are all familiar with and generally condone the eccentricities of the followers of the various artistic pursuits, and when any of their activities become bizarre or grotesque, we merely smile indulgently and offer "artistic temperament" as a valid mitigating excuse.

Although it is somewhat more difficult to accept unusual or erratic behavior among the general run of the population, there is still a tendency to absolve it on the basis of "self-expression" and "individualism," unless such behavior becomes so markedly queer as to justify the person's commitment to a mental institution. It has been truly said that we all have a little of the deranged in us

and that the difference between the so-called normal and the psychotic individual is only one of degree.

Vegetarianism, or fruitarianism as some prefer to call it, is a good example of an eccentric fad which, although not definitely in the domain of the abnormal, attracts to its colors a great many cranks, fanatics, and others who may be considered to be on the fringe of mental imbalance.

There have been many articles written about vegetarians, but chiefly of a descriptive character. As far as the present writer knows, no such article has ever attempted to explain the psychology of a person who, of his own free will, becomes a fervent follower of the cult.

For the sake of clarity, let us briefly mention what is meant by vegetarianism. It consists essentially in the exclusion of flesh, fowl, and fish from the dietary. As is true of all fads, the followers may variously interpret the prerequisites for adherence to the cult. Some include on the taboo list not only the flesh of animals but animal products as well; and such foods as milk, eggs, and cheese are rigorously rejected. Others exclude even grain and pulse foods as being possessed with life-like qualities and limit their regimen entirely to fruits, salads and nuts.

The great majority of vegetarians are so by choice as a result of certain psychological drives and are quite sincere and honest about their opinions. This does not apply by any means to all of them. I recently visited a small town in which is situated the sanatorium of a nationally-known vegetarian. I was amused to learn from a local restaurant-keeper that this famous man is not averse to sneaking in frequently and furtively for a nice juicy steak, and immediately afterward, perhaps, writing an article or a tirade against the barbaric practice of meat-eating.

A great many persons are vegetarians because of religious dictates, among them being the Seventh-Day Adventists, Trappists, and the followers of Vishnu. It should be remembered that practically every religious sect has food proscriptions of one type or another. Thus, Jews shun the pig, Catholics avoid meat on Friday, and Hindus refrain from eating the meat of the sacred cow. These customs undoubtedly represent forms of penance and self-denial, and with such practices we have no quarrel; neither do they

interest us particularly from a psychiatric viewpoint, for man will frequently do things because of religious convictions which he otherwise would not accept or tolerate. Faith is a potent force which is not to be reasoned with logically or derided. Life would be rather dismal were it entirely divorced from an occasional excursion into blind and unquestioned belief.

What interests us more is why a person of apparently normal mental make-up endowed with good intellect and not restrained by any religious dogma, will set up for himself extremely inconvenient and, according to the best medical authority, unhealthful, food barriers. It is even more amazing than if a child persistently refused candy and ice cream. The entire body-economy of the human being is beautifully equipped for an omnivorous existence, as evidenced by the type of teeth, the digestive apparatus, and the ability to eliminate any toxin which may form coincidental with meat-eating. From a medical viewpoint, there is little doubt that, everything else being equal, the meat-eater has the advantage both physically and mentally over the vegetarian in handling the difficult situations of life. Neither is there any evidence to substantiate the belief that meat-eating dulls the mental processes. The Anglo-Saxons are predominantly meat lovers; and there can be little question as to their status in civilization. It is also a matter of note that our greatest moral teachers, Jesus, Moses, Solomon and David, were meat eaters.

Any sincere vegetarian will undoubtedly disagree with this and immediately offer a number of reasons, culled from his cult's literature, proving that meat-abstinence is preferable to meat-eating. First, he will argue, animals are affected by a great many diseases which can be communicated to the human being. Second, the eating of animal flesh produces toxic products in the body, resulting in disease and the shortening of life. Third, from an economic point of view, meat is much more expensive than vegetables having the same food value. The fourth, and perhaps the most important argument he will offer, is that, as civilized individuals, it is morally wrong for us to kill, for our own selfish purposes, beings possessed of the same spark of life inherent in us.

The first three reasons can be argued pro-and-con on an objective level, depending on available statistics and facts. As a psy-

chiatrist, the writer is not particularly interested in their correctness, nor does he have any special desire to prove or disprove them.

The fourth argument, however, is so definitely subjective and on an emotional plane that it immediately attracts our attention. The question promptly arises, "What is there in the psychological make-up of a certain individual to produce in him such a curiously exaggerated compassion for animals?"

The explanation of this idiosyncrasy may, perhaps, become more evident if we momentarily digress from the subject of vegetarianism and consider the psychology of eccentricities generally.

A great many of our odd acts have very little meaning unless they are explained by vagaries of the unconscious. For instance, when a sexually-repressed spinster makes a thorough search of the house before retiring, peering assiduously underneath beds and behind doors, little does she realize that the act in reality signifies an unconscious desire on her part that she may actually find someone there.

Or, consider the case of a patient of mine, who, as if compelled by some unseen force, must resort to washing and scrubbing her hands every few minutes. The natural assumption, of course, is that this woman is excessively clean and detests even the thought of filth. A careful psychiatric study reveals, however, that the opposite is the case. Unconsciously, she is occupied by a great many "unclean" thoughts and desires for which she overcompensates by putting on an outward display of cleanliness. Her apparent aversion for dirt actually represents a liking for it.

I know another woman who is overly concerned over the welfare of one of her children, a boy of 10. She won't allow him to go outdoors unaccompanied, for fear he might "mix with bad company." He is prohibited from playing the usual games indulged in by boys his age, "because he might be hurt." She is constantly having him examined by physicians, restive over the possibility that he may be developing some serious ailment. In general, she is forcing him into an over-protected, cloistered existence which is very apt to lead to his subsequent maladjustment. An unsuspecting person, observing her behavior toward this boy, would attribute it to maternal love and perhaps even extol her self-sacrificing devo-

tion. A study of this case, however, reveals that actually this child was from the very beginning unwanted. Failing in numerous attempts at producing a termination of the pregnancy, the mother unconsciously continued to wish for the child's death for a considerable period following its birth. She now undoubtedly harbors guilt feelings over her attitude and her present oversolicitousness is merely a compensatory reaction for her previous, and perhaps present, homicidal ideas. Shall we term it an attempt at expiation?

The natural conclusion to be drawn from these examples of odd behavior is that any unusual activity on the part of an individual may represent an emotion directly opposite to the one which is superficially apparent. Thus, an excessive display of morality, as in reformers, may actually be due to an unconscious desire to be immoral. Unusual cleanliness may result from the possession of "unclean" thoughts or desires. An extreme display of love may really cloak a hidden hatred, as is evidenced by the fact that false friends often are the most vociferous mourners at a funeral.

When two opposite emotions, such as love and hate, toward the same object coexist in an individual, they are referred to by the psychoanalyst as *ambivalent* feelings. Psychological experience has convinced us of the prevalence of these apparently antagonistic emotions in our so-called normal social intercourse. A careful observer would promptly suspect, for instance, that an excessive and unnatural display of love actually represents an underlying animosity; that an over-exuberant joviality may be merely a cloak for an unconscious morbid sadness; and, that an imperious and tyrannical personality may be only the superficial indication of a hidden feeling of inferiority and weakness.

We can now, therefore, view the vegetarian in a different light. Rather than the sympathetic and compassionate animal-lover, we may perhaps frequently expect to find an individual with underlying tendencies for cruelty and sadism. That such is often the case is borne out by everyday observations as well as by the more thorough studies of the psychiatrist.

Anti-vivisectionists have been known to appear in courts to protest the use of animals in scientific experimentation, wearing fur coats made of animals slain for that purpose.

The author knows of a confirmed vegetarian and zoöphile who is far from being a tender creature toward his family and others, yet feels faint at the sight of blood in the stockyards because of, what he terms, so much unnecessary cruelty. I lost my respect for his sentiments, however, when observation revealed him to be an egocentric domineering bully toward his subordinates, and mercilessly cruel to his wife and children. He is unfair in his business dealings and thinks nothing of taking advantage of a man's unfortunate position or poverty. But let anyone as much as kill a fly in his presence and he immediately becomes loud in his protestations. The coexistence of the ambivalent emotions of tenderness and cruelty is beautifully illustrated in this case, the vegetarianism and love of animals serving merely as a screen for his innate sadism.

Miss S., a single, middle-aged woman, with strong vegetarian leanings, came to me for the treatment of a rather severe neurotic condition. She was possessed by a great many fears of impending danger, she couldn't sleep nights and imagined that practically every organ in her body was in some way affected. She had always been selfish and self-centered and never displayed any concern over the welfare of others. For years her chief preoccupation had been with her bodily processes, and nothing else seemed worth while. The frequency of her bowel movements was a subject of the utmost concern to her, and one which she rarely failed to discuss with others. Peculiarly enough, despite all of her vague bodily complaints, she egotistically expressed the belief that, as a result of her vegetarianism, she would live to be 100 years old. I was tempted to ask her what difference it would make.

Adolf Hitler presents an interesting study in ambivalent emotions. There can be little doubt that a great deal of his terrific drive and energy was dominated by his excessive and psychopathic animosities. His emphasis on "might over right" and his total disregard for the human being as an individual might perhaps be condoned as necessary policies in the unification of the state. His most fervent apologists, however, could find little justification for the unnecessarily brutal methods he employed. The purge of June, 1934, when he killed, or had killed, in cold blood some of his supposedly best and closest friends, men with whom he had been on

intimate terms for a great many years, and without whose aid he would never have reached his position, as Germany's dictator, can be rationally explained only by the man's innate sadism. Nor can any logical excuse be offered for his insanely cruel attitude toward the Jews, Poles, Dutch, Greeks, and others, his mistreatment of the German Catholics, the infliction of the death penalty on many individuals of questionable guilt for relatively minor offenses, and the herding of thousands of human beings into concentration camps on mere suspicion. It must appear highly paradoxical to the average intelligent observer that during the period that these and other sadistic and inhuman acts, displaying a marked disregard for the laws of Man, were perpetrated, stringent laws were being enacted to protect animal life throughout the Reich more adequately, including the marked curtailment of the use of animals in medical experimentation.

The paradox becomes more explicable when we learn that at the time of Hitler's assumption of power, the central organ of the German vegetarian league came out with the flaming headline: "First Great Victory of German Vegetarians—Hitler Becomes Chancellor."

But whether or no some of Hitler's activities appear paradoxical to the average observer, to the psychoanalyst, they follow quite definite psychological laws. One could almost predict a tendency toward vegetarianism in a person of Hitler's temperament without any fore-knowledge of the existence of the condition. Whether Hitler's vegetarian sympathies were partial or complete has not been definitely known. According to a recent biography by Konrad Heiden, Hitler was not an absolute vegetarian but only a partial abstainer. Whether this was true is of little consequence; the psychological implications are nevertheless present. It is thus that his vegetarianism not only reveals a new facet of Hitler's personality but helps to explain a great many of his apparently unexplainable activities.

Benito Mussolini was frequently described by pro-Fascist writers as a kindly man of simple tastes, possessing few personal enemies and dominated solely by the altruistic and unquenchable desire to help his country assume her deserved rôle in European affairs. Even the section in the Encyclopaedia Britannica devoted

to Mussolini, written quite perceptibly by a Mussolini admirer, fails to mention some of the acts which made the name of Mussolini anathema to a great many Italians as well as other intelligent and righteous people throughout the world. There are still many who have not as yet forgotten those cruel "castor oil days," during which human torture of the Mussolini type closely approached in severity the methods of the Inquisition. Is it any wonder that so many risked their own lives in the numerous attempts to assassinate him? Since it is our purpose to point out the relationship between psychopathic cruelty and dietary practices, we are not particularly interested in Mussolini's political theories or his methods of carrying them out, except where they tend to demonstrate such a relationship. Whether Mussolini would have characterized himself as a vegetarian or not we do not know, but we do know that his leanings were certainly in that direction. In his autobiography, he wrote: "As for the love of the table, I do not appreciate it. I do not feel it. Especially in these last years my meals are as frugal as those of a pauper. In every hour of my life it is the spiritual element that leads me on." Then again in Megaro's "Mussolini in the Making," we find the following: "His stay in Trent enriched his experience. He contented himself in living in a room in the poorest section of the town, with a daily fare of beans and polenta."

The vegetarians, anti-vivisectionists and zöophiles may perhaps constitute a very small minority of the population, but, like many minorities, they are extremely vociferous in their protestations. They attempt to influence our home life, our legal apparatus, our educational methods, and to inject their thoughts into every phase of human endeavor. Hardly a day goes by but some new bill is introduced to prevent cruelty to animals. Medical schools are assiduously spied upon by "sob-sister" groups for any violations in animal experimentation. Their influence has been so marked that when a cat becomes stranded on a telephone pole and the "humane" society comes to its rescue it is an occasion for large newspaper headlines and photographs.

Recently a meek, harmless young man was almost lynched in New York City because he checked his little dog in a baggage locker for a short period while attending a movie. No amount of

pleading by the man that he meant no harm, that he liked his dog, and would like to have him returned, was of any avail. The general reaction was that he was an ogre of the worst type. The metropolitan newspapers devoted a great deal of space to the incident. Such a reaction is certainly pathological when we consider what few protests are raised against the crime-breeding slums, against the miserable conditions under which children are forced to be raised in various parts of the country, against the atrocious, inexcusable straits of the sharecroppers, and against other intolerable social conditions and abuses.

We can find little fault or argument with a man's personal preferance for vegetarianism. His choice of diet is as much his individual prerogative as his choice of reading material. It is only when one attempts to force his idiosyncracies on the rest of us and to influence our normal emotional attitudes and evaluations that we ought to resist such interference strenuously. Many of these individuals fight ceaselessly against the use of animals in medical experiments and are extremely sensitive to even the slightest evidence of cruelty to animals while at the same time they display little regard for the suffering of their fellow human beings. Their exaggerated concern over the welfare of animals betrays the utter contempt and hatred which they hold for the human race generally.

I want to reemphasize the fact that the preceding remarks do not apply to all vegetarians. There are undoubtedly some who are convinced, whether falsely or not, of the health benefits of meat-free diets. Generally speaking, however, most of the followers of this cult, particularly those who exploit the humanitarian angle, are basically cruel and unnecessarily malicious. If, for some reason, they do not give, or cannot give, physical expression to their sadism, they may often do this in a modified manner through unwarranted attacks on their fellow-men by means of ridicule, insults, and caustic witticisms—anything to hurt the other fellow. Some have actually become famous, either as authors or public speakers through their uncanny ability to utilize the power of satire and invective; and one can almost picture them gloating over the discomfiture of their targets.

In conclusion, I can truthfully say that in my experience with vegetarians, I have rarely encountered one who could be consid-

ered an entirely normal, well-adjusted individual. The average vegetarian is eccentric, not only as regards his food, but in many other spheres as well. Careful observation of his views on such phases of human relationships as politics, religion, economics, love, and other fields will frequently reveal somewhat twisted and rather peculiar attitudes and prejudices. In short, the average vegetarian is not definitely "a lunatic," but he certainly fringes on it.

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PSYCHOPATHOLOGY OF PSEUDO-HUMBUGS AND PSEUDO-BLUFFERS

BY EDMUND BERGLER, M. D.

External success in life has two results: acknowledgment from the outer world and an inner feeling of satisfaction. Large checks and the social achievement of being a "substantial citizen" are the manifestations of the former, absence of constant reproaches stemming from the inner conscience is a sign of the latter. The present writer became interested in the problem of patients whose external success was astonishing and even out of proportion to their merit, *without* stemming the "hell within," to use Milton's prophetic phrase for the inner conscience (super-ego). In comparing experiences in psychoanalyses of six cases, the writer came to conclusions concerning a special type of neurotic person which he proposes to call the "pseudo-humbug" or "pseudo-bluffer" type. Pseudo-humbugs can be distinguished from humbugs (swindlers) in that, while the latter have psychopathic personalities with criminal involvement, the former are "correct" persons who observe the accepted standards at the same time that their super-egos constantly accuse them of being "fakes." We are concerned here exclusively with the pseudo-type.*

It is very likely not by chance that four of these six patients were specialists in advertising. The fifth patient was a journalist, the sixth a dramatic critic. In other words, all six were exhibitionistically constantly in the public eye.

We shall deal first with the advertisers: Advertising, for instance, radio advertising, is new and does not have the public backing that older types of business have. The outer world has in general the feeling of ironic spite for the "swindle of selling swindle," coupled with jealous admiration for the ability to amass money that goes with it. In reality, there is *basically* nothing dishonest or even suspicious about advertising: The moment you have mass production and masses, a contact must be made between them, and there advertising in its different forms plays its part. Still, it is interesting that the pseudo-humbug has a certain attraction toward

*The writer described the criminal variety in previous papers: "Suppositions about the mechanism of criminosis," J. Crim. Psychopathol., 2: 1943. Further, in "Psychopathology of impostors," J. Crim. Psychopathol., 4: 1944.

that business, despite the fact that we can find him sporadically also in practically every other profession or field of endeavor. The argument which is often advanced that there is more swindling in advertising than in other fields has reference either to the "crooks" found in every profession or to the unheroic beginnings of every profession. *Every* profession goes through a process of purification until it reaches maturity and social standing. Advertising is no exception.

The pseudo-humbug type of advertiser is difficult to describe phenomenologically since the type appears in two contradictory forms, the one openly cynical, the other pompous. Individuals in the first group are always making fun of human stupidity, sparing neither the manufacturer nor the buyer of his products, the public. Those in the second group constantly stress, in a highbrow manner, that advertising is a science, although one which cannot be formulated. Inwardly, both are full of irony and self-reproach, whatever their covering cloak.

Whether these neurotic individuals are copywriters, commercial artists, designers, or business executives, they have certain characteristics in common and a certain specific genetic background. They are basically frustrated writers or artists. The publicity profession attracts persons with artistic or writing *aspirations,* who, because of their inner inhibitions, cannot succeed in their specific fields. With the condition of "prostitution," as one patient expressed it, and of renouncing their "high ideals," they make money. Secondarily, they even look down on the real artist or writer because of his poverty.

The important point is that these persons are constantly haunted by dissatisfaction. One of the patients in question was once an unsuccessful writer. Another insisted that his wife, who showed at one time some ability to write, should write, so that he could, at least by way of identification, enjoy being an author. A third spoke of a book which he wanted to write and never did. Another had ideas that other writers had to execute. The common denominator of these patients was, however, artistic frustration.

The situation of the fifth and sixth patients, the journalist and the dramatic critic, was different, insofar as both belonged to a more acknowledged profession. Both were frustrated writers, the

journalist admitting it, the critic hiding from himself his unproductivity. The journalist was extremely cynical and was proud of having views similar to those of a city editor described in a novel by Kaestner, "Fabian, History of a Moralist" (1932). The city editor in this tale is told that five lines have yet to be filled on the first page, and immediately fabricates the following news item:

"In Calcutta, street fighting flared up between Mohammedans and Hindus. There were 14 dead and 22 injured, though police soon had the situation in hand. Peace reigns in Calcutta."

The episode continues:

" 'But in Calcutta there were no disturbances!' objected Irgarg reluctantly. Then he bowed his head and whispered, out of countenance, 'Fourteen dead!'

" 'There were no disturbances?' answered Muenzer with indignation. 'Please prove that to me. In Calcutta there are always disturbances. Should we inform our readers that in the Pacific Ocean a sea serpent once more made an appearance? Keep in mind, news items, the untruth of which cannot be proven at all or only after weeks, *are* true!' " (p. 35.)

A few pages further we read:

" 'Don't blame him,' remarked the editor of the economic section of the paper to Fabian. 'He has been for some twenty years a journalist, and believes his own lies already. Above his conscience lie ten soft beds and above them Mr. Muenzer sleeps the sleep of the unjust.'

" 'You disapprove of the indolence of your colleague?' Fabian asked Mr. Mallney. 'What do you do besides that?'

"The economist smiled, though only with his mouth. 'I lie likewise, but I know it. I know that the system is wrong. A blind person sees that in economics. But I serve the wrong system with devotion. In the framework of the wrong system to which I lend my modest talent, the wrong measures are naturally the right ones and the right ones obviously wrong. I am an admirer of iron consistency, and besides . . .'

" 'A cynic,' introjected Muenzer, without looking up."

A few pages beyond this:

"Muenzer was sitting in the chaise longue and cried suddenly. 'I am a pig,' he was murmuring."

The problem arises as to why these patients, who made more money than they could have made in other fields, were constantly, either directly or indirectly, on the defensive. They gave the impression that they were always apologizing for their "queer" professions.

All of these people were lonely, having drinking companions but no real friends. All of them were either heavy drinkers or had inclinations to be which they fought, a few more, the majority less, successfully.

The basic mood of all of these patients was superficial flamboyance covering latent depression, or cynicism, or instability of feeling, or depression without any defensive cover. All of the advertisers could become easily excited about propagandistic "campaigns" for a product, for a few minutes identifying with the commercial product, to sink soon into their state of depressed indifference or cynical teasing of themselves and others.

What unconscious drives are expressed in that and similar professions, or, more precisely, what is sublimated? Even a superficial observation shows that people of this type have the "vision," in their flamboyant moments, of seeing their product as the center of the universe. Genetically speaking, voyeuristic (scopophiliac) tendencies are mobilized. That "vision" is transformed into exhibitionism—they must show the public their form of propaganda. There is undoubtedly a short *inner identification with the product they advertise* necessary to achieve such a vision. Here seemingly the difficulty starts: The discrepancy between a five-cent product (to take an exaggerated example) and the megalomaniacal superinflated ego results in the inner ironic reproach: "That's you. You are worth exactly as much as that five-cent product, you fake!" The end is that the masochistic ego is engulfed in self-irony, and the conscience mercilessly flogs the whole personality.

Paradoxically enough, the amount of money made by means of the five-cent product does not mitigate the inner reproach; on the contrary, it increases it. The millions of dollars made through the cheap product are not taken into account except to increase the sense of inner unworthiness. The result is that the person feels like—five cents.

The pseudo-bluffer is therefore always under the pressure of a feeling of guilt, his habitual unconscious refrain being, "You are a fake, a phony, a bluffer." The next question to arise is the reason for this reproach of the inner conscience.

The external reasons given by these six persons (five men and one woman) for entering analytic treatment varied: Two entered

because of potency disturbance, two because of personality difficulties, two because of marital difficulties. All of them were *orally regressed* and clearly showed the symptoms and signs of the triad of the "mechanism of orality." This mechanism consists of a constant unconscious provocation in life of the situation of being disappointed, followed by great aggression toward the self-created enemies, seemingly in self-defense, and afterward by self-pity and the unconscious enjoyment of psychic masochism. Of that triad* only the pseudo-aggression in the act of "self-defense" based on "righteous indignation" and the feeling "Nobody loves me" are conscious. The initial provocation and the psychic masochism are repressed and unconscious.

Besides these oral difficulties, all of these patients had the typical conflicts encountered in creative persons in general—writers, artists, etc. The author emphasized elsewhere† that all writers are orally regressed, a fact first pointed out by A. A. Brill, but that they are no longer striving to fulfill the friendly desire of "getting" in repetition of the child-mother relationship but are full of spiteful desire for oral independence, identifying with the "giving" mother because of *aggression* toward her, thus eliminating her. They achieve oral pleasure for themselves through "beautiful" words and ideas. In its deepest sense, writing, for the creative writer, is designed to *refute* the "bad" pre-Oedipal mother and the masochistically-perpetuated disappointment experienced through her by the establishment of an "autarchy." That oral tendency of autarchy and alleged self-sufficiency is the primary basis of writing in general. Secondarily, on the more superficial level, the specific writer tries to solve his specific inner problems (anal, urethral, phallic, etc.) to which he has turned to escape from orality. What he expresses in his writing, however, is not the direct unconscious wish but the unconscious defense against that wish.

Productive activity in artists is therefore some kind of "self-cure" (Rank). That self-cure is imperiled in the following condi-

*The writer described that mechanism repeatedly in all of its ramifications. The compilation is found in his monograph, "Psychic Impotence in Men," Med. Edition. Huber. Berne. 1937.

†A clinical approach to the psychoanalysis of writers. Lecture delivered before New York Psychoanalytic Society, January 22, 1942. Published in Psychoan. Rev., 31:1, 1944.

tions: (1) disturbance of oral giving; (2) inability to substitute the mechanism of exhibitionism for that of voyeurism (See below); (3) flight from one's problems through a breakdown of the defense function in the creative work; (4) unproductive masochistic moods. Without going into details, the writer wants to stress the fact that in the case of pseudo-bluffers a specific difficulty in the sphere of scopophilia is of prime importance in causing their lack of ability for real artistic creation. Every artist is basically a voyeur (Peeping Tom). Since his voyeuristic wishes are in connection with his mother's breast, he wards them off by means of the defense: "I am not a Peeping Tom; I exhibit my own body" (in artistic sublimation). To illustrate the use of exhibitionism as a defense against voyeurism: A woman patient attended a circus performance with some friends. As she was watching two women acrobats performing on the trapeze, she grew dizzy, covered her face, and exclaimed, "I can't stand it! Please tell me when *that* is over." Voyeurism in this instance was warded off by means of exhibitionism—the woman exhibited by making a spectacle of herself.*

It is difficult to understand why, in the moral code of the infantile conscience, it is a greater crime to look than to display one's self. Perhaps the answer can be found in the fact that voyeurism belongs to the oral phase and exhibitionism to the later phallic phase of psychic development.†

In every writer and creative artist, that substitution of exhibitionism for voyeurism *must* occur or productivity is impaired. *In the case of the pseudo-humbug, a specific solution is unconsciously found: The transition occurs, but only on condition that—humbug is displayed.* In other words, a caricature is set in motion.**

The result is that real artistic productivity is prevented, but its caricature, for instance advertising, is not. What is shown is constant mockery stemming from the sadistic inner conscience (super-

*For details see "A new approach to the therapy of erythrophobia." Psychoan. Quart., XIII:1, 1944.

†In the discussion of the lecture on writers delivered before the New York Psychoanalytic Society, Dr. O. Knopf remarked that one reason for the preponderance of exhibitionism was perhaps the fact that the child is pushed more into exhibitionistic channels by education, which permits him to show off with clothes, achievements, gifts, etc.

**That in the superficial layer *phallic* castration is displayed, too, is obvious.

ego). Thus we see why pseudo-humbugs are usually frustrated writers and artists.*

The combination of oral-masochistic tendencies and the *specific* solution of the scopophiliac ones gives us the clue to the type of pseudo-bluffers. Men of this type also contribute to the understanding of the tragedy of "not taking one's self seriously." The pseudo-humbugs are habitually under pressure of their inner feeling of guilt that they are humbugs. Seemingly, one of the prerequisites of living in peace with one's conscience is the super-ego's acceptance of one's work as real and serious. The moment the super-ego does not accept the work as such, it reproaches the ego, with disastrous results. One could say that the pseudo-humbug does attempt a self-cure, but achieves only a self-cure in—humiliation.

Interesting are the different devices with which the pseudo-humbug of the advertising variety tries to prove to himself that his constant inner reproaches are unjustified. From what the writer could observe, he would say that that type of neurotic uses the four following inner defenses:

1. *Paternalistic attitude.* The advertiser behaves as if the product he is handling is created, not by manufacture, but by advertising. *He* "makes" it.

2. *Contempt for the public.* The pseudo-humbug has a deep-rooted contempt for the common man whom he wishes to reach, is full of irony toward him. He reminds one of a bit of advice which a famous critic gave to dramatic writers: The writer must pretend to be as stupid as his audience really is, so that the audience can believe itself to be as smart as the dramatic writer.

3. *Cynicism.* Cynicism is a specific defense mechanism. Years ago the writer could prove† that the "mechanism of cynicism" has the following structure: Constant pressure from ambivalence and equally constant pressure from the punitive super-ego, which penalizes this very ambivalence, so that the "unconscious compul-

*One could object that perhaps some of the pseudo-humbugs are simply lacking in creative talent. That is possible; their super-egos behave, however, as if they were guilty of misuse of their given talents.

†"Psychology of cynicism," Psychoan. Bewegung, 1933: "Obscene words," Psychoan. Quart., 1936; Chap. I of "Talleyrand-Napoleon-Stendhal-Grabbe," Int. Psychoan. Verlag, 1935.

sion to confess" (Reik) becomes the motive power of behavior. The unconscious ego of the cynic relieves itself of this conflict resulting from the crossfire of an id-striving and a super-ego-prohibition by means of repartee couched in the same form as the original thrust of the assailant. It attempts to prove that *other people possess the same ambivalence.* These "other people" are conceived as part of the subject's own projected super-ego. The cynic's attack is apparently directed toward this external-world moiety of the super-ego; in reality, the cynic is defending himself against his stringent internal super-ego, unconscious, and perceptible to him only in the form of a sense of guilt. The rabid behavior of the cynic does not spring from his aggression; it is the expression of a desperate defensive warfare against his "internal enemy," the intrapsychic super-ego, and it permits the battle to be transferred to "foreign territory." The cynic treats the external world with the same aggressiveness with which his own super-ego treats his ego. At the same time, the cynic attacks his super-ego in and via the external world, somewhat according to the formula: "I strike others but am aiming at myself." Basically, every cynic asks the outer world (here, projected super-ego) to admit that it is no better than he.

4. *Pessimistic outlook and doubts concerning stability of "talent" and "productivity."* All pseudo-bluffers are inwardly full of pessimism, springing partly from their undigested orality, consciously rationalized with doubts as to the continuance of their specific productivity in the form of "ideas." Very typical are their prognoses in connection with "government interference." One of my patients constantly predicted, with malice toward everyone, including himself, that the "unhappy time will come when most of the profits will disappear, because products will be tested objectively by the government, and only those passing the test will be allowed to be popularized." The more solid concerns abstain, even today, from too unscrupulous advertising. Another patient spoke with bitter irony of a manufacturer who wanted his product to be advertised as a "life prolonger." He countered objections to this with actual sales figures, achieved through advertising, which ran high. Said the patient to the writer: "First you make a million dollar baby out of nothing, and afterward you have to use

your own fake as objective proof . . . Do you understand why I call my profession a lot of hullaballoo?''

The feeling of being unjustly treated (See ''mechanism of orality'') was constantly stressed by these patients, and used as an alibi for their ''fake'' professions. This was very obvious in the four advertisers. The journalist mentioned before had a similar approach. The dramatic critic justified his malicious aggression toward younger creative people in this fashion, using self-created artistic ''standards'' as an excuse for tearing down their work ''on principle.'' Characterologically, some of these six patients were borderline cases of ''psychopathic personalities,'' not too trustworthy in general. The majority had correctly functioning egos, but, as is usual with orally regressed persons, were at times capable of strange pseudo-aggressions of which they were justifiably ashamed in moments of self-reproach. Sexually, all six had potency or orgastic disturbances.

The pseudo-humbug suffers from a complicated neurosis, basically in the sphere of scopophilia* and is curable analytically. He does not lose his ''creative'' ability in analysis, as he fears; he can be restored to inner satisfaction and may sometimes even become a writer or artist.

One of these patients, in his constant self-reproaches, quoted Thackeray's statement in ''The Second Funeral of Napoleon:'' ''Humbug they will have. Humbug themselves, they will respect humbug. Their daily victuals of life must be seasoned with humbug.''

But the patient was mistaken even here: He did not even respect humbug.

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*Scopophilia has been, until now, a stepchild in psychoanalysis. The writer suggested that three neurotic entities in which scopophilia plays the decisive rôle, depersonalization, erythrophobia, and boredom, should be subsumed under ''scopophiliac diseases.'' See ''On the disease entity boredom (alysosis) and its psychopathology.'' PSYCHIAT. QUART., 18:2, 1944.

THE RELATION OF THE CHURCH TO MENTAL HOSPITALS*

BY J. BERKELEY GORDON, M. D.

When a clergyman asked me recently to address a welfare group on "The Relation of the Church to Mental Hospitals," I was reminded of the comment of my very efficient secretary, a devout Roman Catholic, who has worked with me for 15 years, on a similar occasion. She said, "For a man who has no religion, it is certainly strange how you are always getting mixed up with these preachers!" To this, I replied in mock seriousness that I most certainly did have a religion, though I never, or rather hardly ever, went to church.

Herein, at the very start of our discussion, we begin to quibble about, "What is religion?" This question is even harder to define than "What is psychiatry?" a sufficiently elusive and nebulous field in all truth, but since it is so intimately associated with the physical body, not quite so purely abstract as religion. These two disciplines, religion and psychiatry, have certain broad fundamental similarities with much common ground; and at the same time they share certain basic weaknesses and shortcomings which impel me to use the term discipline rather than science, though I expect both theologians and psychiatrists to rise up in consequence and stone me.

To begin with their similarities: It is obvious that both religion and psychiatry are concerned with ideas, thought processes, mental mechanisms, emotions and symbols of various types. The priests of these disciplines are concerned with the soundness or "truth" of the ideas, the emotional energies and stresses associated with them, and the behavior or life-adjustment produced by them. But unfortunately there is no absolute standard in either case by which to judge the soundness of such ideas. Herein lies the great common weakness. The test of the ultimate worth, orthodoxy and acceptability of ideas and behavior in each case is the interpretation of the experts, the theologian and the psychiatrist. But these persons, being human and subject to the same imperfections, biases, prejudices and emotional stresses as other mortals,

*Read at a symposium on religion and mental health at the Forty-fourth Annual Conference of the New Jersey Welfare Council, Newark, N. J., November 29, 1945.

can only interpret according to their own backgrounds and conditionings. The mental content of each patient or parishioner is examined by another individual who, to be sure, is possessed of some special training and knowledge but who nevertheless, having no absolute standard, must translate and interpret according to his own background and personality. Hence what is schizophrenic ideation to one is definitely within the bounds of the normal to another; and what is heresy to one is entirely acceptable to another equally renowned churchman.

I have been asked on the witness stand if I had applied the "test for insanity;" and I have replied that there was no such test. Indeed, there are thousands of such tests, but none of them infallible, and all of them dependent on the judgment, the objectivity, and the psychic balance of the interpreter. For this reason, we also have a multitude of different religions, with subdivisions within subdivisions; geography, climate, racial background, language differences, and countless other factors modifying the choice. Likewise, we have equally competent, ethical and conscientious psychiatrists asserting with great vigor and heat diametrically opposite opinions as to the sanity of the same individual. This, I assure you, is not necessarily, or even usually, because the experts are biased, prejudiced, or incompetent but because each one must interpret according to his own understanding.

Since both religion and psychiatry deal with abstractions, it is convenient and necessary to employ symbols in conveying our ideas. All language, both written and oral, is of course symbolic, and, of all fields, psychiatry and religion are probably the most highly verbalized. Indeed it is natural that highly verbalized individuals should gravitate into these two highly-verbalized specialties. Great prolixity is a natural penalty. Words are the tools of the preacher and the psychiatrist, and the efficiency of these people in achieving their objectives depends on their choice and use of these symbols. Here judgment and psychological timing play a major part, for verbosity can spoil a sale, keep people away from church, and drive patients to your briefer-spoken colleague. Truly is it said that few souls are saved after the first 30 minutes of the sermon. It is important to know when to stop talking as well as

what to say and the over-verbalized preacher or psychiatrist succeeds in being a bore and hence a mediocrity.

This combined field represents an area of dual jurisdiction for the priest and the psychiatrist, where intelligent cooperation on the part of two specialists, both striving for the same result and neither possessing the perfect formula, results in an effective combat team which can achieve objectives beyond the power of either one alone. The position of authority which the religious leader occupies in society makes him particularly valuable, when properly trained, in bringing to light painful and confidential psychiatric material and psychic traumata of a deeply personal nature, which are inaccessible to the physician no matter how good the rapport. This harmonious personal relationship is, or perhaps I should say should be, already established between the parishioner who develops mental illness and his priest. Thus in the course of psychotherapy and reeducation when the relationship between patient and therapist becomes blocked and unproductive, the impasse can be hurdled many times by calling into consultation the priest, who can resolve certain types of difficulties with which he is fitted to deal and reestablish productive relationships. He can speak with the voice of authority and confidence which is so comforting to the mind that is confused and sick and uncertain of its spiritual landmarks.

All of the major systems of theology conceive the Deity as an omnipotent force who uses His absolute power with mercy and gentleness; who looks upon His erring children with a kindly and tolerant eye, willing to forgive them if they repent their transgressions and honestly strive to conform to His laws. In certain types of psychoses, especially the involutional and the depressed cyclothymic, this belief in the benevolent paternalism of the Deity is lost and the conviction of utter hopelessness, unforgivable sin, and the necessity of eternal punishment is substituted. This is the reason for being of one of the hospital executive's major problems: suicide. The prevention of self-destruction and the relief of the misery which engenders it is often the natural responsibility of the priest, because most of the psychic factors involved, as distinguished from the organic, are the result of the violation of religious taboos of both a doctrinal and sexual nature. One also oc-

casionally sees the patient who has reversed and perverted the almost universally held belief in immortality to believe that since death is so desirable and life so infinitely worse than death is, he is condemned to live forever and cannot achieve the oblivion of death which he so desires. Here the patient's adviser may have the seemingly paradoxical task of convincing him that death will come in God's own time and that he is not condemned to the infinite misery of eternal physical life.

Many patients over-react to sins which we have all committed, and condemn themselves to what corresponds to capital punishment for the most trivial and universal offenses. Indeed, our belief in the benevolence of the Creator is a defense mechanism, since without it life would be intolerable and suicide logical.

In many instances, the priest can assist the social worker, or function as a social worker himself, in establishing the truth or falsity of delusions; that is to say, whether certain beliefs of a plausible nature are false and therefore delusional or are true. The whole question of a patient's sanity often hinges on this point. We know, for example, that persons are sometimes poisoned by crafty and shrewd spouses who want to get rid of them. We have it at least on good authority that infidelity does occur. But did this woman's husband really try to poison her, and is this man's wife really entertaining a lover while he is at work or overseas; or are these beliefs entirely false and unjustified, the productions of sick minds? To find this out is to tax the detecting ability of a Sherlock Holmes and to demand the wisdom and ability to analyze human character of a Solomon. Here again we are dependent on the personal interpretations of fallible human beings who rarely are able to ferret out the absolute truth. Is it strange that psychiatrists sometimes disagree on a patient's mental health? The religious leader, by reason of his position in the community and the nature of his personal relations, is in a position to relieve great misery, prevent injustice, and assist in the diagnosis and treatment of such patients.

One of the major ways in which the church can assist the mental hospital is in interpreting it to the community. And, speaking for myself, I can say that we have needed a great deal of interpreting during the last few years. If it be true, as is sometimes said, that

psychiatry is the sick man of medicine, then it is true because, lacking the precision of surgery and related specialties, psychiatrists have failed to develop properly the more subtle material with which they deal and to educate the public in the truths about mental disease, its cause, prevention, and cure, as certain other specialists have succeeded in doing, notably the doctors who treat tuberculosis, heart disease and cancer. If anything good can be said to have come out of this war it is the tremendous focusing of attention on, and the awakening of public interest in, the importance of mental disease and psychic traumata as a cause of loss of manpower, human efficiency, and productive citizenship. What can be accomplished for the sufferers from mental disease by an intelligent campaign of public education, such as we have seen in the campaign against tuberculosis, is actually beyond our imaginations. Dr. Alan Gregg pointed this out in his very significant paper at the 1944 meeting of the American Psychiatric Association.

It is more than a quip to say that "all the world is crazy except thee and me, and thou art a little crazy," because I am also "a little crazy!" Let us remember this and shout our wares with becoming modesty. There is no such thing as perfect mental health any more than there is perfect physical health, or a perfect human eye. As the melancholy Dane remarked, "I am but mad north-northwest: when the wind is southerly I know a hawk from a handsaw." Can the church help to get such truths across to the public, to "debunk" psychiatry, and raise the level of public understanding of mental disease? It can if it will train its workers, by including psychiatric training and psychiatric interneships in its own educational program, and selecting those who are particularly well fitted for the fields of social service and mental disease. Every priest at times must be a psychiatrist, and every psychiatrist must be a priest. (Again I expect to be stoned!)

The church through its agents can in many instances allay the doubts and dispel the fears and misconceptions of relatives who think that their loved ones are to be the subjects of abuse and experimentation in mental hospitals. The minister can often win the cooperation of the family and get the necessary permissions for "shock" and other therapies by establishing the family's faith in the competence, ethics, and good will of the medical staff.

Likewise, accidents and injuries—which occur even when mental hospitals are at normal peace-time levels of personnel and have been much more frequent during the depleted-personnel conditions of the war years—can be explained to belligerent relatives, who often have little appreciation of the reasons such things occur. It is obvious, though, that in order to do this, the minister must know what he is talking about and be able to answer natural questions with knowledge and authority.

In the foregoing, I have indicated, briefly I hope, in broad general terms how the church can be of assistance to the mental hospital. I would not leave the impression that this is a unilateral benefit, for I believe that the mental hospital can likewise help the church. There is a growing tendency toward the establishment of full-time resident chaplaincies in mental hospitals, and I believe that it will not be long before this will be a requirement for meeting the standards of the American Psychiatric Association. In addition to their work of a psychotherapeutic and sociological nature with the patients, these chaplains can be used directly as teachers of ministerial students or theological internes, and as teachers of the community clergy. Three to six-month residencies in mental hospitals under the supervision of a resident chaplain have been found extremely valuable in the reorientation of chaplains coming out of the armed forces, who find themselves in need of additional study of psychiatry before resuming civilian pastoral work. The importance of mental disease has been impressed on army and navy chaplains, especially on those who have been in combat, so that there is an increasing awareness of the problems of mental health in all phases of ministerial work. After several years in uniform under most abnormal conditions, demobilized chaplains returning to civilian life are likely to go through periods of confusion and doubt, requiring careful and not too rapid readjustment. The study of one's fellow-man can oftentimes hold the mirror up to nature and enable us to see ourselves and our own problems in an exaggerated form and thus give insight into our own personalities.

We psychiatrists have found that community clergymen are eager to learn something about the human personality in health and disease, and about the fundamentals of mental mechanisms. These men are usually married, with the responsibilities of a fam-

ily and full-time pastoral work. They cannot stop work and put in three or six months of psychiatric residency in a mental hospital, which they agree is the ideal program. What they can do is to devote one full day a week to a seminar conducted by a resident chaplain; and, in the course of a year, through attending lectures and staff meetings, studying case records, and working on the wards, acquire sufficient knowledge of human personalities, including their own, to be better pastors, and what is just as important better husbands and fathers. Without this training, the average minister is rather badly handicapped in handling or even recognizing problems of maladjustment which he is seeing every day whether he recognizes them or not. Eventually, courses in mental hygiene and abnormal psychology will be a part of all undergraduate theological curricula, and theological interneships in psychiatry will be considered as essential for the young minister as for the physician.

In closing, may I recall to you Macbeth's agonized plea to the court physician concerning the deranged Lady Macbeth, a plea which might serve as a motto for all of us, no matter what our titles, who are concerned with human welfare and social problems:

> "Canst thou not minister to a mind diseas'd,
> "Pluck from the memory a rooted sorrow,
> "Raze out the written troubles of the brain,
> "And with some sweet oblivious antidote
> "Cleanse the stuff'd bosom of that perilous stuff
> "Which weighs upon the heart?"

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PSYCHIATRIC ASPECTS OF THE LAW OF HOMICIDE

BY G. M. DAVIDSON, M. D.

I

Controversial opinions have been expressed regarding psychiatric aspects of criminal law. For instance, Justice Holmes stated that the law is made to govern men through their motives, and it must, therefore, take their mental constitution into account. Obviously, such opinion calls on the psychiatrist to give more than mere advice. Judge Cardozo went even further in observing that he expected medical science to solve certain difficulties of the criminal law pertaining to homicide. On the other hand, there are such statements as that made by Professor Wharton, namely, that the question of criminal responsibility must be upheld by the law and the "horse sense" of the jury, since the doctor may have a "wild" theory to suit his case.

The modern view on the problem is that lawyers should be primarily concerned with the reform of administration of the criminal law. The social scientist is expected to make his contribution regarding the causes of crime by studying the latter from a sociological point of view. As to the rôle of the psychiatrist in the problem, it appears to the present writer that his duty is to investigate criminal activity as a manifestion of the total personality. The investigation must take into account all relevant data on the subject which may be produced by anthropological, biological, psychological, sociological, medical, etc., research.

The aim of such an investigation is to achieve the ability to arrive at a correct diagnosis of a situation. While the question of diagnosis is very complex, the effort toward achieving this aim must remain untiring, because only a proper diagnosis will enable one to give an answer to the question of criminal responsibility, to outline proper treatment, be it medical or judicial, and to make it possible ultimately to work out a system of prevention.

The foregoing appears in harmony with the observation of Dean Pound that a satisfactory administration of criminal justice must rest ultimately on a satisfactory criminal law. The beginning of the latter may be seen in the further observation of Dean Pound

that perhaps the most significant advance in the modern science of law is the change from the analytical to the functional standpoint. Such an attitude requires judges, lawyers and jurists to keep perpetually in mind the relationship between law and living social reality, a "law in action." To develop such an attitude, the legal mind has to rid itself of the "tyranny of concepts" (Cardozo) and "legal fetishism" (Geny), as the psychiatrist had to do with certain "traditional" medical concepts to be able to understand the dynamic manifestations of the total personality.

With the foregoing comment, the writer wishes to submit the results of his own study and reflections on the subject, even at the risk of being accused of offering a "wild" theory. To make his view sufficiently intelligible, it is necessary to review briefly certain aspects of the law of homicide inclusive of its semantics, as well as to review certain medical and psychiatric studies on the dynamics of the personality and the operation of the psyche.

To begin with, the writer would like to point out that the Anglo-Saxon law of homicide distinguished: (1) murder, (2) manslaughter, and (3) justifiable homicide. In the first instance it is assumed that the act follows a state of mind involving the intent to cause the death of a person; in the second, the state of mind is assumed to be one indicative that, while the actor probably knows what the act may cause, he hopes that no harm will occur, or he is indifferent to it, or the act occurs incidental to other activity; in the third instance, judgment is involved, and it is not relevant to the present inquiry.

In the United States, beginning with the Pennsylvania act of 1794, the law sought to limit the infliction of the death penalty in homicide by introducing two degrees of murder (first and second). Various states differ in definitions of the degrees of murder. For instance, the State of New York considers murder in the first degree to be the result of a "deliberate and premeditated design" to effect the death of the person killed; or to be the result of an act without premeditated design but imminently dangerous to others, or to be any killing by a person engaged in committing a felony. In other states, like Alabama and Arkansas, the killing must not only be "deliberate and premeditated" but also "malicious." The state of Delaware requires "express malice aforethought." Mur-

der in the second degree in the State of New York constitutes killing with the intent and design to effect the death of the person killed but without deliberation and premeditation. Manslaughter in the first degree in the State of New York constitutes the killing of a person in the "heat of passion" with a dangerous weapon. If there is doubt as to the dangerous nature of the weapon, the offense then becomes manslaughter in the second degree. The law makes also reference to an irresistible "impulse to kill." An irresistible impulse, to be of avail, must result from mental disorder, and not from natural passion. Passion caused by jealousy will not excuse a person from criminal responsibilities (State vs. Lauth, 46 Ore. 342).

The foregoing discussion emphasizes the terms *malice aforethought, deliberation, premeditation, design, intent* and *impulse,* not to speak of other concepts. To sum them up, these terms refer in their turn to concepts of affectivity and of the *will,* as well as to to the element of *time,* subjects to be discussed next.

II

"Malice aforethought" is a product of English reasoning. It may be assumed that the term was originally conceived in its true affective sense. Subsequently it was reduced to a purely technical concept. For example, Kenny states "a modern student may fairly regard the phrase malice aforethought as now a mere arbitrary symbol . . . for the malice may have in it nothing really malicious, and need never be really aforethought (except in the sense that every desire must necessarily come before—though only perhaps an instant before the act which is desired)." In 22 states the statutes contain express reference to homicide as "evinced by a depraved and malignant heart," still a reference to affectivity.

American law introduced the terms "deliberation" and "premeditation," thus turning from apparent reference to affectivity as the background of homicide to the "will." However, here also a reduction of the concept took place. Consider the terms mentioned. According to standard dictionaries deliberation means: to consider, to take counsel with oneself or with others, to act slowly, which in turn implies acting in "cool (cold) blood;" and it further implies the passage of time. Premeditation means to

think over carefuly, to form a plan, a process which also implies "cool blood" and the passage of time. The term "design" appears to refer to the process of reflection and involves a time element, a concept fairly close to "premeditation." Impulse, on the other hand, would imply a sudden urge to act without reflection, to commit an act of instantaneous consummation (the time element cannot be appreciable). Now, consider Section 1046, of the New York Penal Law: ". . . such killing of a human being is murder in the second degree when committed with a *design* to effect the death of the person killed, or of another but *without deliberation and premeditation.*" Here one can see the confusion that must follow by attempting to understand what "design without premeditation and deliberation" can mean. The explanation would seem to lie in the accepted axiom that a man's intention be judged by his action—if there is killing there must be intent to kill—but this is only true as a generalization in the sense noted by Kenny.

To illustrate, the writer would like to quote Judge Wallace in a recent trial: "If you find that the defendant committed such an assault, it gives you the right to infer that he intended to take a life. But it does not mean that you must draw that inference." (Peo. vs. Lonergan.) Even such a liberal attitude does not clarify the situation.

To illustrate further: " . . . deliberation and premeditation imply the capacity at the time to think and reflect, sufficient volition to make a choice and by the use of these powers to refrain from doing a wrongful act." (Peo. vs. Barberi, 149 N. Y. 256.) This is plain and logical. But consider this: ". . . deliberation is also premeditation but is something more. It is not only to think of beforehand, which may be but an instant but the inclination to do the act is considered, weighed, pondered upon for such a length of time after a provocation is given as the jury may find sufficient for the blood to cool. One in a heat of passion may premeditate without deliberation. Deliberation is only exercised in a cool state of blood, while premeditation may be either in that state of blood or in heat of passion." (State vs. Kottorsky, 74 Mo. 247.) It is obvious here that the good judge is lost in his semantics, the tyranny of concepts and legal fetishism.

Again: ". . . a design to kill formed at the instant of killing where there is no deliberation and premeditation preceding the act is murder in the second degree . . . there must be some appreciable space of time for such deliberation. Yet the opinion is that the time must not be necessarily long." (Peo. vs. Guadagnino, 253 N. Y. 344.) Here the judge frankly expressed his own perplexity, to which one may add the observation of Cardozo: ". . . there can be no intent unless there is a choice, yet by the hypothesis the choice without more is enough to justify the inference that the intent was deliberate and premeditated. The presence of a sudden impulse is said to mark the dividing line. But how can an impulse be anything but sudden when the time for its formation is measured by the lapse of seconds? Yet the decisions are in the effect that seconds are enough. What is meant as I understand it is that the impulse must be the product of an emotion or passion so swift and overmastering as to sweep the mind from its mooring. A metaphor is however to say the least a shifting test whereby to measure degrees of guilt that mean the difference between life and death. The present distinction is so obscure that no jury hearing it for the first time can fairly be expected to assimilate and understand it. I am not at all sure that I understand it myself after trying to apply it for many years of diligent study of what has been written in the books." Nothing more illuminating can be offered than the foregoing observation of an outstanding legal mind.

The writer will comment later on the medical aspects of the terms discussed. For the moment, he will turn to another aspect of the law of homicides.

It is a legal presumption, subject to rebuttal, that all men are sane and intend the natural and probable consequences of their acts. The burden of proof to the contrary lies upon the claimant and those acting upon his behalf. Various tests measuring responsibility have been evolved. For instance, Lord Erskine held that delusion is the true character of insanity where there is no frenzy or madness. In our times, we deal principally with the "knowledge of right and wrong" test.

The New York Penal Law, Section 1120, states: "An act done by a person who is an idiot, imbecile, lunatic or insane is not a crime.

A person cannot be tried and sentenced to any punishment or punished for a crime while he is in a state of idiocy, imbecility, lunacy or insanity so as to be incapable of understanding the proceeding or making the defense. A person is not excused from criminal liability as an idiot, imbecile, lunatic or insane person except upon proof that at the time of committing the alleged criminal act, he was laboring under such defect of reason as: (1) Not to know the nature and quality of the act he was doing, or (2) Not to know that the act was wrong."

In addition, Section 34 of the Penal Law, states: ". . . a morbid propensity to commit prohibited acts existing in the mind of the person who is not known to have been incapable of knowing the full wrongness of such acts, forms no defense to a prosecution therefor."

The "knowledge of right and wrong" test, as phrased by Lord Brougham following the McNaughton trial in 1843, would recognize only one kind of right, namely, when one acts according to law, and only one wrong, which is when one breaks the law. Lord Bramwell commented in 1874 that the law lays down such a definition of madness that almost nobody is ever really mad enough to be within it. Again, Justice Stephen in 1888 observed that the test of responsibility is in the *power of discriminating* between right and wrong.

To illustrate further, the writer would like to quote Judge Cardozo (Peo. vs. Schmidt, 216, N. Y. 234) who refers to Judge Nott (Peo. vs. Purcell, 214 N. Y. 693) ". . . the knowledge of the nature and quality of the act has reference to its physical nature, and that knowledge that the act is wrong refers to its moral side that to know that the act is wrong the defendant must know it is contrary to the accepted standards of morality." Such differentiation brought on the doubtful concept of legal vs. medical insanity. For instance, Judge Rodenbeck (Peo. vs. Nyhan, 171 N. Y. 466) observes: ". . . there is a distinction . . . between insanity as the term is understood in medical science and insanity as the term is understood in legal science, so as to relieve from criminal responsibility. A person may be insane, as the term is ordinarily understood, and still be responsible for the commission of the crime." This brings us back to the observation of Lord Bramwell just quoted.

We have seen the attempts of the legal mind, as voiced by Justice Stephen and Judge Cardozo, to differentiate the concepts of the right and wrong formula. Zilboorg discusses it from a psychoanalytic point of view: ". . . between purely verbal or intellectual knowledge as may be observed in children and the knowledge of the adult or mature knowledge which is a complex mental operation and is affective in nature. Therefore defect of reason which the law stresses, does not lie within the field of reason at all, but within the field of emotional appreciation." This is akin to the interpretation of Cardozo concerning morality. One cannot, of course, separate intellectual from emotional aspects of the process of appreciation of an act, but must take into consideration the psychology of the act *in toto,* a matter on which the writer will comment later.

As a rule, the question of criminal responsibility is considered as an *all-or-none* reaction. However, there is also the notion of limited responsibility. For example, the attitude of the law of Scotland on partial responsibility was stated by Lord Alness in the case of Savage in 1923 as follows: ". . . now there may be such a state of mind of a person, short of actual insanity, as may reduce the quality of his act from murder to culpable homicide . . . It is very difficult to put it in a phrase, but it has been put in this way; that there must be aberration or weakness of mind; . . . that there must be a mind so affected that responsibility is diminished from full responsibility to partial responsibility—in other words, the prisoner in question must be only partially accountable for his actions."

In line with the foregoing, may be cited the New Hampshire rule that the question of fact for the jury in each case is whether the defendant had a mental disease, and if so whether it was of such character or degree as to take away the capacity to form or entertain a criminal intent.

Here also comes in the semantics of the law as put by the Penal Code of the State of New York that: "An act done by a person who is an idiot, imbecile, lunatic or insane is not a crime." As the condition is defined at present, an idiot is a person of the lowest form of mental development, as manifested from birth or very early life. His mental age, as measured by the Simon-Binet or similar scale,

does not exceed two years. He can do almost nothing for himself, cannot wash or dress, and cannot safeguard himself from common physical danger. He does not appreciate the phenomenon of death and cannot possibly form a plan of action. He cannot possibly commit murder in accordance with the formulation of the law. Criminal intent is an essential element of crime. If a person is mentally unable to form such intent he cannot be regarded as guilty under the law (Com. vs. Hathaway, 13 Mass. 299). Why then have this provision relating to idiots in the law at all?

An imbecile is a person who is not far removed from an idiot. His mental age does not exceed seven years. He cannot manage his own affairs under the most favorable circumstances. Here, again, it cannot be assumed that an imbecile can form or entertain a plan of action such as is necessary to commit murder. There is no need to have specific mention of imbeciles in the law. A feeble-minded person could—under some circumstances—commit murder. The terms lunacy and insanity are usually used synonymously. Historically, the term "insanity" came into popular use in England in the seventeenth century; it developed to replace such terms as madness and lunacy. This in its turn ought to be done away with, since it obscures the law. The New York State Department of Mental Hygiene led the way in this respect by banning all such terms from the Mental Hygiene Law.

V

The foregoing brief chapters have served as an introduction and an orientation in this subject. In this chapter the writer would like to discuss certain factual data on the problem, such as those pertaining to the background and make-up of the murderer, as well as to certain aspects of psychopathology.

To begin with, let us quote Baker, who studied 50 inmates of Sing Sing Prison who had been sentenced to death for murder in the first degree. Baker concludes: "It may be stated that one convicted of murder in the first degree and sentenced to prison to be executed is usually a white male under 30 years of age, born in this country of foreign parents of the laboring class; that he possesses a very fair degree of intelligence and education; has not acquired skill in any trade or profession and is usually unemployed

at the time of his offense. He is not found to have been a previous problem. He is in good health with a negative blood Wassermann. He is not psychotic. He does not develop a mental disorder or attempt to feign a mental disorder during his incarceration awaiting execution." This excellent summation covers considerable ground with reference to such factors as race, age, sex, occupation, mental and physical states, etc. The socio-economic factors have, no doubt, a considerable bearing on the problem, as may be seen from statistics on homicide. For example, the "Quarterly Bulletin" of the Department of Health of the City of New York for March, 1945, shows that at the height of economic depression in 1931 the death-rate from homicide was 8.4 per 100,000 population, while the same rate for 1944 was only 2.9. From the standpoint of total personality, causative factors may be studied on the level of the psychological constellation of the individual which is psychiatry's primary task.

To cite further reports on the subject, Banay pointed out recently that the criminal cases he studied showed an emotional immaturity nearest to the defective child's reactions. However, he said that the average mental age of the criminals was 13 and one-half years. A characteristic trait in his cases was the capacity for trigger-like action of mangnanimous and heroic nature.

Rosanoff, in his study of "30 condemned men," distinguishes a type of a so-called habitual, professional offender, in whose case murder is incidental to the purpose of theft, burglary or robbery. In contrast, the previously noncriminal reacts desperately to a sense of grievance, injustice or outrage when he kills. In this group murder is often committed with a suicidal impulse or with an actual suicidal attempt.

Rymer reported 63 cases of homicide in which 35 per cent of the killers were found "insane," the rest considered "sane." The diagnoses in the former group were: schizophrenia, paranoid states, psychoses with mental deficiency, senile psychoses, psychosis with cerebral arteriosclerosis, psychosis with syphilis of the central nervous system. The diagnoses of the "sane" group were: hysteria, mental deficiency, psychopathic personality, alcoholism and "normality."

As to the relationship of a particular mental disorder to homicide, certain clinical findings may be significant in connection with other data. For instance, it has been pointed out that a so-called "unmotivated" crime may occur in the course of schizophrenia. On the other hand, even if the act committed by a schizophrenic should show something in the way of planning, the impression is that the individual acted as an automaton. Of course, the schizophrenic who commits murder in the belief he has a mission from God to do so, or that he is the Lord himself, does not require special comment. As to paranoid states (paranoia, paranoid condition), a crime may be the result of delusional ideas such as those arising from pathological jealousy in which instance the actor may lie in wait for a marriage partner or his or her supposed paramour and kill. Or a crime may be the result of any other paranoid attitude. It is unusual for the manic to kill unless as a result of general distrust. The depressed criminal is of interest. For example, a person, overwhelmed with the depressive idea of being ruined economically and morally, may kill members of his family to save them from shame and misery. The situation is especially noteworthy in infanticide (for details see the writer's study on the subject*), and in depressions of middle life. In the so-called organic psychoses, such as general paresis, murder may be the result of hallucinations, of delusions, of misidentification, or may be the outcome of fear and apprehension for one's own safety, the patient acting at times as if in self-defense (delusional). Murders of a sexual nature of children by elderly persons are related, not to the organic state, but rather to involutional changes, as described in the present writer's study of the subject. In epilepsy, homicide may be committed in the state of epileptic furor or in a similar state. The murder may be rather brutal. The question of amnesia in such cases will be discussed later. With modern tests for epilepsy such as the electroencephalogram and the Rorschach test in addition to a good psychiatric study, there should be no difficulty in recognizing the situation. Psychosis with mental deficiency and psychopathic personality will reflect the make-up of the individual such as his simplicity, immaturity, impulsiveness, and the child-

*See Bibliography.

ishness of his revenge and rivalry; murder may be committed by such persons for trivial reasons.

In alcoholism, murder may be committed on the basis of paranoid delusional states as well as because of misidentification. There are no particular characteristics. The question of amnesia will be discussed later. As to psychoneurosis, the writer personally doubts that a psychoneurotic, whether the hysterical or the obsessive-compulsive type, is able to kill. It is not known that a compulsion is ever translated into murder. Theory seems to confirm this view, since the essential of the theory is that the psychoneurotic converts his conflict or builds up a defense against the conflict. Again, in anxiety states, the anxiety prevents one from being able to choose action.

Concerning the psychopathology of homicide, the writer believes that a great deal may be learned from observations on suicide, because of the frequent interchangeability of the conditions surrounding the acts. Mental cases, in particular, show the coexistence of homicidal and suicidal wishes and ideas. According to psychoanalytic theory, suicide is rooted in sadism; it is caused by an identification mechanism; the suicide identifies himself with the love object he has lost; in killing himself he kills his love object. Again, suicide may be committed to avoid forbidden activity (murder). The murderer may discover in the victim the hated and forbidden parts of his instinctual drives: Thus, in killing, one gets rid of such drives. According to Wittels, the criminal psychopath is a bisexual narcissist who kills one of his sexual components which he projects outward. Zilboorg observes that murder is an acting-out of patricide. Again, there is a general notion that the murderer has an unconscious wish to be punished for the guilt he feels. Therefore, he leaves, ever so often, a clue so as to be apprehended. Dostoyevsky's "Crime and Punishment" is freely quoted in this respect. The validity of such generalized ideas is doubtful.

As to aggression leading to homicide, anthropological research shows (Margaret Mead) that aggression may be largely determined socially. In fact, aggression belongs to the defense of the ego against fear. It may be a form of compensation for feelings of inferiority and insecurity of various levels of the personality. Rank observes that aggression has the tendency to transform the

aggressor's own suffering into the pain of the person from whom the suffering comes. The finding of Baker that the Sing Sing offender is usually a native-born child of foreign-born parents gives food for thought. The discrepancy between the attitude toward life of the parents and the one created in the offspring by American education is very great. Result—rebellious aggression.

Study of case material shows that motives alone (mental content) conscious and unconscious cannot account for homicide. One must evaluate also the affective state at the time of homicide; and this has been studied surprisingly little. Toward this end, the writer would like to call attention to his study of the final common path of the total personality. The final common path is identified with affectivity. Here one may comment on certain aspects of affectivity. Impulse is a constituent of affectivity; it is humoral and biochemical in its source, bound up with endocrine, autonomic and psychic activity which flows over in the motor function and associated functions (Kretschmer). The will is another aspect of total affectivity. From a psychological viewpoint, human behavior is a compound of psychological growth. In the process of growth, the primitive structure is compounded with new values and psychic needs. The will is therefore a dynamic process in which the motives of the self are in a constant state of nascency. Voluntary behavior is based upon the ability to bring out and to subordinate incoming impulses.

VI

As already mentioned motives alone cannot explain homicide. Even if one could be altogether certain WHY a person commits murder the answer would not be exhaustive, for the reason that homicidal wishes are ever so often expressed while the act is seldom committed. Therefore, in addition to answering WHY a person murders, it is also necessary to answer the question of HOW it comes about that one person kills another after all the usual conditioning to the contrary. The question of HOW this comes about refers to the mechanism of the act. Here is where the concept of the final common path of affectivity is useful. The reasoning follows.

Homicide is an act. A human act is the motor end of a process which has at its other end a thought or an idea. At least, one outlines the process in that way to be able to form a mental picture of it. Such an attitude toward human actions is demanded by our intellect, which requires, for its grasp of things or events, structure, even if in the form of a phantom. Any inquiry into the ideational end of the process leading to murder shows, of course, that the ideation pertains to death of another person. (The psychology of the meaning of death cannot be entered upon here.) The ideation may be expressed in a direct or indirect wish, either in an overt form or as a symbol or a metaphor. The wish may remain inactive for an indefinite period, may recur as an idea, or may culminate in homicide or suicide or both. (Here is where such legal concepts as "deliberation" and "premeditation," appear to be rooted.) When there is a homicide, one thus has a fusion of thought and action. It is this mechanism of fusion that may explain how it comes about that the act is committed. To understand the mechanism, consider the phenomenon described as a "dominant." Spemann has shown that in amphibian development there is a central zone constituted by the dorsal lip of the blastopore in the gastrula stage which assumes the lead, controlling the fate of the rest. Coghill, basing his views upon his studies of the salamander, reached the conclusion that normal behavior depends upon the sovereignty of the total pattern of activity over all the partial patterns of activity.

The clinical application of the dominant is outlined by Ukhtomsky. This author holds that various centers of the nervous system may not act at times in the usual manner. He shows that, in the presence of an excitation that he calls "dominant," some mechanisms may be shut off. For example, by stimulation of a certain region of the cerebral cortex of an animal, a perfectly defined local reaction may be produced, for instance, the twitching of a leg muscle. However, if the animal is about to perform the act of defecation, the same stimulus applied to the cortex, at the same point, will no longer produce the twitching of this same muscle. It appears that the pathway is blocked because cerebrospinal centers are aroused and are dominating at that particular moment. As soon as defecation has taken place, the blocking is released.

Experimental evidence shows that any impulse may become a "dominant." Everyday experience teaches us that the same observations can be applied to man. It is possible, therefore, that various impulses, as well as motives like those studied here in connection with murder, may become "dominant." The motive will represent, in a direct or indirect form, the individual's conscious and unconscious difficulties. An impulse once aroused will seek discharges; if not discharged, any additional experience (as shown by experiment) will only accentuate the symptoms and speed up the overflow of the neuroendocrine, or the psychical or their combined activity in the associational and motor fields. Fatigue, with the resultant diminution in the acuity of the sensory apparatus, will facilitate development of a dominant. Alcohol and physical disease, in causing accumulation of affect around the "self," will likewise serve to facilitate the way of an impulse in becoming dominant.

VIII

The overflow of the dominant into the motor sphere is apparently caused by contraction of consciousness, which, in turn, is an accompaniment of the dominant excitation. Concomitant with the contraction of consciousness, there is a dulling of the senses, with a consequent decrease of the ability to receive impressions from the outer and inner environment. The flow of production and subordination of impulses (the will) will cease, and, with it, will cease the normal, automatic rejection of what is unhealthy. An extreme contraction of consciousness is seen when homicide is committed by command of "voices." The development of such a state of fusion of thought and action is accounted for otherwise by the patient himself. For example, a patient who decided to end suffering by suicide related that she went up on the roof of the house where she lived to jump. When at the edge of the roof, she would repeatedly step back because of a counter-idea that such death would be worse suffering than she was undergoing. She also tried suicide by gas, opening and closing the gas jets with the same result as on the roof. This kept on until counter-ideas became weaker and weaker; finally, no counter-ideas came forward, and she did attempt suicide.

Approximately the same situation is to be found in homicide. The writer studied a number of persons who attempted homicide by stabbing. These persons gave similar accounts—that the urge to stab was recurring with simultaneous ideas to the contrary, until the mounting irritation became dominant, no counter-ideas appeared, and the person stabbed his alleged adversary.

Such manifestations of thought and action are comprehensible if one considers that the evolution of thought is concomitant with evolution of affectivity. In the well-organized total personality, thought is independent of action; in many instances it is a substitute for action; or action may follow thought after an interval. On the other hand, one observes in children of a certain age the inseparability of thought and action, particularly well expressed in speech, which is a motor end of thought. The same thing may be observed also in the immature personality, with impulsiveness resulting. Furthermore, it is noticeable in dissolution of the personality, as seen in certain psychoses.

Before decisive conclusions may be reached on the mechanism or mechanisms of a homicide, further exhaustive study is necessary. As the problem stands now, it is only possible to say that since homicidal wishes are prevalent and since few persons attempt homicide, a special psychoneural constellation is necessary to facilitate the act. While the nature of this constellation is not known in detail, it is evident that the total personality (constitution plus environment) participates in its creation. In general terms, the situation might be akin to the "pathological inertness of the excitatory process" in the sense of Pavlov, that is a weakening, under certain circumstances, of the inhibitory function of the neurons. Pavlov observes that accentuation of emotions may cause excessive stimulation of neurons, leading to pathological inertness. The latter will in turn cause ideas and feelings to become irresistible (in our sense dominant), even long after the real cause is withdrawn.

IX

If the foregoing outline of the mechanism of homicide is correct, then one must ascertain in each case the nature of the dominant of the situation. This, in turn, will facilitate the diagnosis. It has

been seen that a dominant may arise on any level of the total personality. Therefore one could not analyze all instances here, but a few examples will be given.

First, take the notorious case of McNaughton (1843). The defendant shot and killed Drummond, mistaking him for Sir Robert Peel, because of the belief that the latter had blasted his reputation, had followed him and had made his life miserable. This case gave the basis for the "knowledge of right and wrong" test. From the legal viewpoint, McNaughton had intent to kill. There was deliberation, and he "knew" what he was doing. From the viewpoint here presented, McNaughton was able to form a plan of action; and he shot and killed a person whom he believed to be persecuting him. This was a delusional belief, a projection of affectivity. What is called deliberation is in reality the maturing of a trend toward dominancy. The dominant here is rooted in threatened security. The false belief makes the threat stronger. McNaughton's "knowledge" of the act is a knowledge devoid of judgment. There is inability to choose what action he will take because, at the height of expression of the dominant, there is a regression from cortical to primitive thalamic affectivity, intense and widespread, which facilitates fusion of thought and action.

Second, there is the case of a young man with an excellent record who shoots and kills another person because the latter has humiliated him in front of friends over a considerable period. Legally, this offender has had intent to kill, one could say that there was premeditation. He "knew" the nature and the quality of the act. His act would conform in certain states to the legal definition of first degree murder. However, on appeal, his sentence would presumably be commuted because there is such persuasive evidence of provocation. The juridical and administrative reactions, here are, of course, disrupting to the proper administration of law. Psychiatrically, in the sense presented, one has here a person who was able to form a plan of action. The act was rooted in a fact. There was no delusional attitude. There was no projection of affectivity, but there was accumulation of affect around the self. This accumulation of affect was mounting (interpreted as premeditation) over a long period, finally reaching the height of a dominant. At that time, there was no possibility of a choice of

actions. While the two cases differ in their development, at the end, they run the same course. The dominant is rooted here in another basic psychic need, that of recognition. This was threatened by the activity of the adversary.

Third, consider a case of murder occurring in the course of robbery. The offender falls into the type of individual described by Baker. According to law, he committed murder in the first degree. In the sense discussed here, this offender is also unable to choose his line of action at the critical moment because he has a peculiarly-conditioned affectivity which acts in a trigger-like fashion in the face of danger. There is an instantaneous fusion of thought and action, without reflection. The dominant is rooted in threatened security. The conditioning forces which lead to such a psychoneural constellation or to such affectivity may be found in a life-long process of transforming shortcomings into aggression. In many instances, an individual's basic psychic need for recognition and response is involved in this process of conditioning.

Fourth, take the case of a middle-aged man, single, maladjusted sexually, socially and economically. While under the influence of liquor and while he is being visited by a small girl, a neighbor, he begins to manipulate her sexually. The child, having experienced pain, cries out, at which moment the defendant chokes her to death. The law would have no difficulty in finding the offender guilty of murder in the first degree. However, from the viewpoint of this paper, one can see that there was an instantaneous overflow of an impulse into the motor field in face of fear for security. Psychopathologically, one has here a maladjusted person going through involution, a period when there is a flare-up of libido. This is increased by alcohol which prompts the man to his sexual offense and later facilitates the expression of the dominant.

X

In conclusion the following may be emphasized:

There is no single cause, mental or physical, for homicide. The causes are multiple. In most cases, the setting is one of threatened security to basic psychic and physical needs.

To understand the mechanism of homicide one must be able to answer not only the question of WHY one person kills another, but

also that of HOW it comes about that he kills. The understanding may be facilitated by the concept of the final common path of the total personality; and this is identified with affectivity. Affectivity is also the background for the phenomenon described as the "dominant." The dominant represents directly or indirectly, overtly or symbolically, a person's conscious and unconscious difficulties; and it may be acute or subacute in its development. The dominant, once created, constricts consciousness, focussing affectivity upon its object. This reduces judgment to nil and interferes with the ability to choose between or to subordinate incoming impulses. Finally, there is a regression of affectivity from cortical to thalamic, with an overflow of the impulse into action (homicide). The concept of the dominant has biological, physiological and psychological value; therefore, it invalidates such concepts as "deliberation," "premeditation" and "design"—which are only verbalizations—as measuring instruments for murder. The concept of the dominant also throws light on the true meaning of such concepts as "heat of passion," or "irresistible impulse." Furthermore, it gives an idea concerning the possible significance of the element of time in murder.

The approach outlined suggests that, with the exceptions of inadvertent homicide by accident and of killing in self-defense, there is only one type of homicide.

From the viewpoint of this paper, any person who kills another, who is known to have been able to form a plan of action, as the act has shown, is guilty of murder. The term, "not guilty for reason of insanity," is improper and hampers proper administration of the law. A person found guilty undergoes either juridical or psychiatric treatment. The aim in either instance is social rehabilitation, not punishment or correction. The New Hampshire rule may serve as a basis for the future working out of a law of homicide. The Briggs Law of Massachusetts which provides that a psychiatric examination be done in any case of capital offense ought to be adopted universally. It is believed that such measures, among others, may prove helpful in doing away with the insanity plea.

The term "temporary insanity" is improper and ought to be abandoned. A person may have a psychosis from which he may

recover promptly. The psychosis must be specifically diagnosed. Such procedure will facilitate adequate disposition. In case a person commits murder in the course of a psychosis and subsequently recovers, such a person should not be discharged but certified as a mental patient and placed on convalescent status as such. This measure would also be helpful in doing away with insanity pleas.

Testimony of amnesia as evidence of "temporary insanity" and as evidence that there was no intent to kill on the part of the offender ought not to be accepted. Amnesia following homicide has the same psychological characteristics and significance as amnesia following head trauma. The acts of the trauma and of homicide produce a common characteristic—that of not remembering the blow. The mechanism is one of the repression of a painful experience. The "cure" of the offender in such cases of homicide is akin to the cure in persons who recover from suicidal attempt. The act helps to repress or to discharge the conflict.

With reference to responsibility in alcoholism, mental deficiency or psychopathic personality, the presence or absence of a psychosis associated with the condition in question is a guide.

An either-or philosophy in measuring responsibility is inadequate. Social rehabilitation ought to be guided by evaluating the total personality on the lines suggested here.

Finally, it is suggested that the terms "penal" and "correctional" be abandoned and that "social rehabilitation" be substituted for them. For example, there ought not to be a Penal Law but a Law of Social Rehabilitation; there ought not to be a Department of Correction but a Department of Social Rehabilitation.

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THE SELECTION OF CASES FOR SOCIAL TREATMENT

BY ELINOR S. NOETZEL

In selecting cases for social treatment, one must think in terms of what social treatment has to offer patients, for the diagnostic skill exercised in such selection will, in a large measure, determine the degree of success.

Two responsibilities are assumed in treating patients in mental hospitals and State schools—one to the patient, the other to the community. While these responsibilities are not in conflict, first consideration will be given, for the purposes of clarity, to the services social workers can offer their patients; later, their responsibility to the community will be discussed.

State institution social workers probably look with envious eyes at the private agencies which take only those patients who come asking for help. The State institution's patients are brought to them. Even the voluntary patients are likely to come only after long persuasion. Before the patient accepts the State social worker as a person who can help him, the social worker must prove himself.

When the social worker first meets a patient in the institution, the patient may be resentful, hopeless, hostile, or confused. The patient must find in the worker a person who can accept him without censure or anxiety. There may be only a slight service to offer, such as word of his children or conservation of his property, sometimes it will be only listening to him. If one meets a need he recognizes, there will be a warm emotional bridge over which his feelings can come to the worker. One patient said of her worker, "She helped most by listening to me. I was confused and hopeless. When she listened, I felt she thought I would get well, and that gave me new courage."

When we meet a patient in this crisis situation, there is an opportunity to get ourselves asked into his life; and without this invitation we can accomplish nothing. It is our chance to get to know him as a person rather than as a case, and to find out the stress and strain that has led him to seek refuge in illness or asocial behavior. At this point, we need our best diagnostic skill

to determine whether we have anything to offer him; also to determine how much will be needed to protect him from himself, or others from him.

Mental patients, according to Dr. George S. Stevenson* have lost the ability to conduct their affairs with satisfaction and effectiveness due to a breakdown in behavior. It is our task to help them to regain this ability in some measure. Human nature being what it is, satisfaction is more important to the patient than effectiveness. Can we help him to gain any satisfaction? We have little to offer him if he is complacent. We ask if he realizes that there is anything wrong with him? Not necessarily does he understand the full gravity of his illness, but does he recognize that he has in any way contributed to his problem. He has suffered a disturbance in his interpersonal relationships. Can he or will he change? If he cannot or will not, will the person in his environment, with whom he clashes or who dominates him, modify his attitude toward the patient? If not, we might select such a patient for a therapeutic family-care placement. Or if he has difficulty in adjusting to his employer, can we find a more understanding one?

At this point in selection, it must be decided whether the focus is to be upon the patient or the environment. If it is to be on the patient, he must want help, must have some realization of his problem, and must be capable of using a relationship. Often patients with the more deep-seated affective disorders, such as schizophrenia, are able to use a relationship only to a limited degree and our emphasis must be on lessening the strain of the environment.

Not only must the patient be able to use a relationship, but the worker must be able to establish one quickly. Sometimes in social work, we are thrilled with our own cleverness in detecting mechanisms of behavior and forget the kind of person our patient is. Is it any wonder he squirms under our dissection, and that we then decide he cannot use a relationship? If we see him as a person, he generally responds. Is he lonely, hostile, frightened, or just plain tired? Then we may ask how he got this way, and what the worker can do about it? It may be only standing by, just being there and

*Social Work Year Book, 1943. Russell Sage Foundation.

sharing with our own understanding and warmth the pain of his frustration.

Those with supervisory experience know how workers differ in their ability to meet individual needs. One excels in the ability to establish and maintain a relationship, another in her ability to get the more executive things done in the enpironment; and sometimes it seems too bad that it is not possible to assign cases on this basis rather than the more practical one of geographical area.

Our case loads are enormous we all know, and no matter how much we may dream of loads that are reasonable, we shall probably never have them. It is simply too expensive to provide enough workers. Hence, one must think in terms of selecting case loads for service. We can represent one graphically as a pyramid. At the top, there will be a few cases with the most needs, upon which we will put forth the most effort and time; at the base will be those whose needs will be less urgnt.

What are the types of service social workers have to offer their patients? First, there will be a large number of patients whom I shall have to call "sitters," for want of a more elegant term. These would include deteriorated patients in their own homes or in custodial care. These persons need food, clothing, medical care, shelter, understanding and a simple environment.

In such cases we shall focus our treatment on the environment. We shall educate the family to take the greater part of the care. The family may need all of our skill to sustain its members through a trying time. It is necessary to be particularly alert to see when the strain is becoming too heavy for a relative to bear. It is certainly not good mental hygiene to destroy the effectiveness of a non-psychotic member of a family for the sake of a mentally-ill patient. Such a case may require intensive work, but it will be concentrated upon the family rather than the patient. When the family has learned to accept the patient without too much strain, and has learned to call upon us in need, we may not need to go back. Let the family get him a job, arrange his recreation and take him to church. Frequent check-ups may look well for our industriousness, but, when we go, we should have something more to offer our patients than merely running to see how they are. We have all striven to avoid having the patients think we are just "watching"

them. Alas! too often we are. A patient senses when we are offering nothing but surveillance, and justly resents it.

There will be other patients, whose needs may be best met by community resources. In this type of case, we must be sure that our patient is ready and willing to use the resources, and that they offer him the same satisfaction that he finds in the destructive patterns that contribute to his illness. I remember well a young delinquent girl who frequently wandered away from home to the horror films. After an exquisitely hair-raising evening, she would find her way to the police station and tell the sympathetic sergeant she was afraid to go home. He would see that she was proudly escorted home in a prowl car. When I offered the Y. W. C. A., it was too tame and meant nothing to Anna. In spite of my frustration, I myself sympathized with Anna's delight in the prowl car. I could not translate the Y. W. C. A. into Anna's emotional language.

On the other hand, Walter was very different. He was a colored veteran of 20, who came to the clinic and could accept what the community could give him. He had received a medical discharge from the army because of gastric ulcers. He sought help because he had headaches, which he was sure were due to "nerves." He had lived most of his life in Florida. His parents were separated. His mother inspired him with ambition for an education. He had been inducted immediately after he had finished high school. He told the doctor he had had long crying spells after he went into the army. His sergeant was from Syracuse. He had suggested that the boy should come to Syracuse and enter the university, where he could take the course he desired in bacteriology. He had arrived with a few dollars in hand beyond his tuition. He immediately found himself in a disappointing environment. He was lonely, frightened, and disappointed that the northerners did not treat him better than the southerners. He had sought a doctor of his own race to treat his ulcers. This doctor was going into the armed forces and referred the boy to the dispensary, which, in turn referred him to the medical service at the university. He had seen the doctor there once, but he did not return, apparently because he was not ready to accept this service. He presented economic, medical and emotional needs. He was referred to the local Vet-

erans' Bureau. His mustering-out pay was obtained for him and his vocational rehabilitation program arranged. He was a good boy and resented the pool hall loafers of his own race whom he had met. The serviceman's secretary at the Y. M. C. A. cooperated to the extent of finding three new friends for Walter. He also opened the facilities of the swimming pool to him. The worker was able to interest a clergyman and a colored business man in the boy. When he felt he had some backing and was told that the doctor at the university wanted to see him, he went back and continued his treatment for his ulcers.

The worker had a very superficial relationship with the boy, except to show him a warm, lively interest; but he laid hold upon and used community resources to such an extent that the headaches disappeared and the ulcers healed.

In such cases, treatment is indirect. One manipulates the environment with full awareness of the patient's psychology, but he is not particularly cognizant of what the worker is contributing to him.

We shall find other cases who can be served best by family or child welfare agencies. There may be instances where intensive case work is needed with other members of the family; or children may need the protective services of a child welfare agency. In such cases, the community social worker may take over the whole problme with the psychiatric worker acting as consultant. In such a situation, the psychiatric worker must be willing to share her knowledge of the patient and his family relationships with the community worker. In other cases, they may both work together, with the psychiatric worker focusing upon the patient and the community worker concentrating upon the family. Of course, in such a situation there will be need for careful planning between the two agencies so that the patient may not play one agency against another as a child plays one parent against another.

There will be a small number of patients who can profit by direct treatment. These will be those who come asking for help. Their seeking may be inarticulate, but sometimes they may tell us they feel better after talking to us. These patients will be divided into two types. The first wants help in understanding his feelings. The second needs to express his feelings to lessen his interior ten-

sions. We all know the patient who can be kept on even keel by talking out paranoid ideas. We may be able to help a manic patient by teaching him to understand his drives, and showing him how he is exhausting himself, with resultant irritability and excitement. We have to teach him to live on his small margin of mental strength, and contribute to his acceptance of himself as he is.

In treating these cases, we shall need close consultation with the psychiatrist, for there is always a tendency to get in over our heads. We shall need the psychiatrist's aid, not only in treatment, but in helping us to watch for red danger flags along the way. We all have seen cases of patients, who have brought out their hostility over a long period and then have turned it upon themselves and become suicidal. We need to evaluate critically whether our patient really wants to do something about his problems or just wants to be soothed. We must ask ourselves whether there really is progress in movement or whether we are allowing the patient to wander more deeply into his neurotic maze. Psychiatrists have taught us that the patient should face the reality of his liabilities. At the risk of being a heretic, I believe our patients who have been badly battered around by life have a greater need to be made aware of their personality assets. Our own love of people will help us to find these assets. Our warmth and understanding will be our greatest tools in meeting the need of our patient for a relationship. Perhaps we shall have to do a little-soul searching to find out if we have sufficient richness of personality ourselves to help our troubled patient. If we are guilty of insincerity our patients will never be too psychotic to recognize it.

There may be cases which we shall select for their educational value to the staff. I know one worker who could not appreciate that the irritability of a mild arteriosclerotic was a symptom of illness. He was assigned to a very deteriorated arteriosclerotic who, he could see, was a very ill man. He returned to his supervisor and said, "After I have worked with this second patient I can see that he is simply an exaggeration of the patient who annoyed me so much."

There will be cases we select for research purposes. In this category there will be such patients as those who have had convul-

sive therapy. Social workers in the state hospitals and schools need to do more research, not only with those cases in which our physicians ask our help, but with those that will help us toward discovering new case work techniques. For example, we have found that a few of our patients who have had convulsive therapy profit by a more passive approach than is generally needed with patients who have had spontaneous recoveries. This might present an interesting research problem for a social worker.

There will be cases we shall select because we have an obligation to the community. When we think of our community responsibility, we must face freely and realize frankly that we are an authoritative agency. Social workers, in their swing away from the days when Lady Bountiful dispensed her largesse with an authoritative hand, passed through a period when they thought authority something slightly indecent. After all, authority is a reality in life. There is a vast difference between using authority as a case work tool and assuming an authoritative attitude. The use of authority is a challenge to the social worker's own integration. If her punitive urges or her anxiety overcome her, we shall find her assuming an authoritative attitude.

Most of our patients have had difficulty in adjusting to authority. They have reacted with fear and have become too submissive, or they have reacted with open hostility. If the worker is wise enough to establish a warm emotional contact before she uses her authority she may be able to give to the patient the experience of finding out that authority can be exercised justly and for his own protection. In the use of authority with our patients may we make a plea for greater frankness with them. We do not summarily tell another agency that is our policy to do as we do, but we give the reasons for our action. Let us treat our patients with the same courtesy; they may be more reasonable than we think.

The State has delegated to us the responsibility of seeing that our patients do not kill themselves or someone else, and of seeing that our arteriosclerotics do not endanger the morals of children; and we shall have to meet our responsibility fairly and without anxiety. These cases are perhaps our most discouraging ones, but let us remember that the understanding and sympathy we give

them may be all they will receive and their need for service is just as real as that of the patient with a better prognosis.

Summary

In conclusion let us summarize briefly: The basis of the selection of cases for social treatment will be primarily consideration of the patient's need, and of whether we can meet this need. Our patients' needs may be economic, medical or nursing care: they may call for adaptation and use of community resources such as group, case work, or employment services. We have a responsibility in preparing our patients to accept community services. We may supply their needs by teaching their families to accept and understand them. Again, we may help a patient most by supplying a relationship which will be a dynamic one aimed toward greater effectiveness and satisfaction for the patient.

We may select cases for their educational value to the staff.

Cases may also be chosen for research value, not only to assist the medical staff, but for research in case work techniques.

We must accept the responsibility the State has placed upon us to protect the community and to protect the patient from himself. In assuming this authority, we shall try to use it as a case work tool and teach our patient that authority is not something identified with the severity or leniency of his parents, but is a protection that gives him greater security.

If we find that we cannot meet the patient's needs and that neither he nor the community needs our protection, is it too radical to say we have nothing to offer? We are often loath to admit that there are certain third-stage social cancers that we cannot treat. It is, perhaps, a sign of an advanced stage of training to be able to realize what we cannot do. A certain number of cases with poor prognosis might be carried as research projects; but let us not waste too much time that might be spent more productively on other cases. There are cases which should be definitely rejected as well as selected for social treatment.

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THE VALUE OF DIAGNOSTIC SIGNS FOR SCHIZOPHRENIA ON THE WECHSLER-BELLEVUE ADULT INTELLIGENCE TEST

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The clinical psychologist has fortunately moved on from the rôle of a technician whose sole duties are to establish deficiency and classify the individual on the basis of I. Q. alone, to a position which demands of him the interpretation and explanation of all his findings in order to obtain a more thorough understanding of the individual subject. It is now well recognized that the I. Q. itself has rather limited meaning and should be complemented by a qualitative analysis of intelligence, even for the so-called normal or average subject. To be of true service, the psychologist must analyze and interpret all the factors which go into a test score, determine special abilities and disabilities, explain deviations from expected functioning and, in general, interpret the subject's total intellectual performance.

For this purpose, certain clinical instruments are more helpful than others. The Wechsler-Bellevue adult intelligence test is particularly adapted for this, because its subtests have all been equated by means of weighted scores so that the results of any one test can be compared directly with the results of all the other tests. Moreover, Wechsler has published considerable statistical data obtained from his standardization groups, and these can be used for comparative purposes.

In attempting to understand the mental functioning of abnormal groups, schizophrenics have received more attention than most other clinical types, and there is in the literature a relatively large number of studies dealing with schizophrenia and the Wechsler-Bellevue adult intelligence test. Rabin[1] gives the rank order for various Bellevue subtests as found in schizophrenic patients. Weider[2] compared the Bellevue test results for an older and younger group of schizophrenics and indicated which tests he found discriminated between the normal and the schizophrenic. Magaret and Wright[3, 4] compare the functioning of schizophrenic patients on the Bellevue with the results obtained from other clinical types. Their findings are somewhat at variance with those

of other investigators; and they are somewhat skeptical of accepting "diagnostic signs," as found in test results, as indicative of mental disturbance without further qualification. Gilliland, Wittman and Goldman[5] found schizophrenic subjects less variable than their controls.

Wechsler, in his latest edition, has enlarged his chapter on "Diagnostic and Clinical Features.[6]" He gives data which, according to him, may with certain limitations "be accepted as clinically valid." For each clinical type he indicates the relative position of the 11 subtests which make up the total scale. The following calculations are involved. The sum of the weighted subtest scores and the mean subtest score is calculated. Scores which fall 1.5 to 2.5 points above the mean are marked +, scores falling 3.0 or more points above the mean are marked ++, scores falling 1.5 to 2.5 points below the mean are scored —, and scores falling 3.0 points or more below the mean are scored ——. Scores which fall between 1.5 points above and 1.5 points below the mean are scored 0. The following test-results from a schizophrenic patient illustrate the procedure.

Information	9	0
Comprehension	7	—
Arithmetic	4	——
Digits	9	0
Similarities	8	0
Picture completion	7	—
Picture arrangement	9	0
Object assembly	13	++
Block design	9	0
Digit symbol	10	+

Total 85; mean 8.5.

In addition, Wechsler offers the following signs: 1. Verbal is higher than performance scale. 2. Sum of picture completion and comprehension is less than the sum of information and block design. 3. Interest variability is marked and greater on the verbal than on the performance scale.

In this case, scores of 8 and 9 are marked 0; scores of 10 are marked +; 12 and over ++; scores of 7 are marked —; those below 6, ——. Actually Wechsler suggests[7] that in "certain instances where the discrepancy between performance and verbal is

very large it is desirable and often necessary to treat each part of the examination separately.'' In the study discussed in this present paper, this procedure was used.

The Wechsler-Bellevue test results of 40 patients clinically diagnosed as schizophrenic were analyzed, according to the method described in the foregoing in order to evaluate these ''diagnostic signs.'' These subjects were all inmates of the Clarinda State Hospital, Clarinda, Iowa.* Sixteen are males, 24 are females. The mean age of the group is 35.8 years, and the range 19 to 52. The average I. Q. for the group is 91.0, range 61 to 112.

The results for each subject were carefully evaluated against the signs given for each clinical group. Subjects who showed an excess of positive signs for schizophrenia were called schizophrenics, those showing an excess of neurotic signs were called neurotics, etc. When there were equal numbers of signs for more than one clinical type, the subject was labelled borderline. Sometimes a subject showed an excess of positive signs in two clinical groups; and he was then placed in the group in which he gave the larger number of positive signs. Thus for example, one subject gave seven positive signs for neurosis and six negative ones, but also gave nine positive signs for psychopath and only four negative ones. He was, therefore, classified as a psychopath. Where, however, the subject gave seven positive signs for psychopath and six negative ones and also showed the same distribution when analyzed for neurosis, he was called borderline or unclear. Where no clinical type gave an excess of positive signs, the subject was left unclassified.

In view of the fact that Wechsler does not state how many positive signs must be present to make a diagnosis, the final diagnosis must be left to the judgment of the examiner. In the present study, an excess of even one positive sign was considered sufficient for diagnosis. Since the vocabulary test had not been administered, there were 14 signs used for diagnosing schizophrenia, 12 for organic states, 13 for psychopathic personality, 13 for neurotic, and 12 for mental deficiency.

The tables show how the 40 clinically-diagnosed schizophrenic subjects were diagnosed by Wechsler's ''signs.''

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TABLE 1. TEST RESULTS ON 40 SUBJECTS CLINICALLY DIAGNOSED AS SCHIZOPHRENICS

Type	Number	Percentage
Schizophrenic	13	32.5
Psychopathic	10	25.0
Neurotic	3	7.5
Mentally defective	4	10.0
Organic	3	7.5
Borderline	4	10.0
Unclassified	3	7.5

TABLE 2. 40 SCHIZOPHRENIC SUBJECTS DIVIDED ACCORDING TO SEX

Type	24 female		16 men	
	No.	Percentage	No.	Percentage
Schizophrenic	7	29.2	6	37.5
Psychopathic	7	29.2	3	18.7
Neurotic	2	8.3	1	6.3
Mentally defective	3	12.5	1	6.3
Organic	0	0	3	18.7
Borderline	2	8.3	2	12.5
Unclassified	3	12.5	0	0

When the 13 subjects who were diagnosed as schizophrenic by the signs of the test are broken down into type and compared with the total group, the results shown in Table 3 obtain.

TABLE 3

Group	No. in total gr. 40	No. in diagnosed gr. 13
Simple	18	5
Paranoid	11	4
Catatonic	4	1
Hebephrenic	6	3
Mixed	1	0

It is apparent from this that Wechsler's diagnostic signs are no more signficant for one type of schizophrenia than another.

On the basis of these results, it can be said that for these 40 cases, correct diagnosis would have been made by the Wechsler-Bellevue test in only 32.5 per cent of the cases and incorrect diagnosis in 67.5 per cent. In that there are actually five possibilities under consideration, namely, schizophrenia, psychopathic person-

ality, organic brain disease, neurosis, and mental deficiency, correct diagnosis should occur 20 per cent of the time on the basis of chance alone. From the statistical point of view, Wechsler's signs increase the chance possibilities for correct diagnosis in these 40 cases, roughly, by 60 per cent. Inspection of the results shows a prepotency in the direction of schizophrenia. Actually however, from the clinical point of view the signs are almost valueless. If incorrect diagnosis occurs 67.5 per cent of the time, the instrument has little to recommend it.

Actually, it is obvious merely from the inspection of the signs given by Wechsler that they could not be consistently helpful in diagnosis. There is a tremendous overlap of signs for the different clinical groups, and no attempt is made at weighting them. There is only minimal indication of pattern or general Gestalt to be expected, and "diagnosis" depends in the last analysis simply on the presence or absence of certain proffered clues.

To any experienced clinical psychologist, the variety of test-results obtainable from the schizophrenic patient, or for that matter from any type of patient, is an old story. To illustrate how impossible it is to use this type of + and — concept in diagnosis, the following results from two of the schizophrenic subjects used in this study are given in Table 4.

TABLE 4

Test	Pt. aged 39 Simple schiz.	Pt. aged 37 Simple schiz.
Information	6	11
Comprehension	6	4
Arithmetic	4	6
Digits	2	4
Similarities	4	3
Picture completion	2	6
Picture arrangement	8	4
Object assembly	12	2
Block design	8	7
Digit symbol	4	7
Verbal I. Q.	73	80
Performance I. Q.	89	80
Total I. Q.	80	79

Here are two schizophrenic patients of about the same age, about the same I. Q. and both of the simple type, yet giving very different test results. In the first case the verbal I. Q. is 16 points lower than the performance I. Q.; in the second case, verbal and performance I. Q.'s are identical. In the first case, the information and comprehension scores are identical; while, in the second case, the information is outstandingly high and comprehension very low. Yet Wechsler says that the comprehension varies from + to — "depending on the type of schizophrenia." Since both of these subjects are of the simple type, the question is which one should be credited with a positive sign for schizophrenia and which with a negative one. Obviously, the patients are performing in very different ways. Again, for the first subject, the object assembly test is his outstanding score; while, for the second case, it is the lowest score.

There is no need to belabor the point by continued illustration. It is apparent that this type of diagnosis on the basis of "signs" as given by Wechsler is not clinically helpful. In spite of this, it is most important to realize that test-results can be used as diagnotic aids and that an experienced clinical psychologist would have made the correct diagnosis not because of the signs or in spite of them, but because of his experience and understanding of schizophrenic performance. Thus for example in the first case, the subject's inability to handle essential details in spite of his excellent organizational ability would have been strongly suggestive of a severe disturbance in functioning of the type seen in schizophrenia. This suspicion would have been reenforced by the discrepancy between the subject's ability to recall general information and his inability to concentrate for even short periods as indicated by his present memory score. Each subject must be evaluated as an individual, with all the salient facts in his history carefully held in mind. In such a way, test results can be clinically meaningful.

In summary, it may be stated that the use of Wechsler's signs for the diagnosis of schizophrenia on the results of the Wechsler-Bellevue adult intelligence test was not helpful when applied to 40 patients who were inmates of a state hospital; and correct interpretation was made in only 32.5 per cent of the cases. This should

not be considered proof that psychological tests, particularly the Wechsler-Bellevue test, are not valuable aids in diagnosis, but only that the specific method offered is not a valid one.

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HOSPITAL SHIP NEUROPSYCHIATRY

BY JAMES A. BRUSSEL, M. D.*

Physician and layman alike, upon first hearing of psychiatry and hospital ship mentioned simultaneously, probably dismiss the entire subject as an uninteresting and unimportant link in the chain of evacuating casualties from theaters of operations to the zone of the interior. Despite the time-worn definition of a hospital ship as an "ambulance at sea," it is surprising how much care and treatment can be administered to soldiers disabled by virtue of mental illnesses. This presentation, however, will not confine the orientation to the shimmering assets as such, but will also present the handicaps and disadvantages of psychiatry at sea and, where possible, offer certain suggestions for future improvement in such a service.

The writer's hospital ship experience was confined to the U. S. A. H. S. *Frances Y. Slanger,* the former Italian luxury liner, the *Saturnia,* and the largest hospital ship in the world. This vessel had a bed capacity of approximately 1,600 of which roughly a third was allocated to the neuropsychiatric service. The latter was located aft on decks B, C, and D and in two holds or hatchways. The forward hatch contained from above to below, the N-P mess hall, the disturbed ward, and one ward for "open" patients. The aft hold, from above to below, contained a ward of 80 berths (beds to us and the army) for officers, divided into four sections which could be maintained either as open or closed units, and two wards for open patients. Maintaining close organization and supervision of these six divisions was very difficult because of the bulkhead between holds which meant that a nurse, medical officer or corps man who wished to go from the lowest ward in the aft hold to the lowest ward adjoining *on the same deck,* had to climb three flights of ladders (stairs to the landsman) and come down as many to complete what, in a land installation, would be the walking of a dozen steps. Only one ward (officers') and the mess hall had portholes. The other two decks, being below the water line, had no natural ventilation; but ventilation was allegedly provided by arti-

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ficial means in conjunction with a well-known electrical air "purifier." However, exhaust vents were vastly insufficient, and the intake vents were inadequate and too often not working. As a result, the air-purifying process which, according to the pamphlet supplied by the manufacturer made possible "air as sweet as that of the mountain or seashore," was a meaningless and ineffectual mechanism. The only time that living conditions were comfortable in these "underwater" quarters was in the neighborhood of the English and French coasts where the chilly dampness provided some relief. Otherwise ship personnel and patients alike, suffered from oxygen insufficiency and from the inhuman heat. Fatigue, drowsiness, headache and gastric distress were constant complaints which were relieved, not by medication, but by organized trips to the open decks for patients at stated intervals, and by off-duty hours for personnel.

One of these "submarine" wards, however, was the disturbed ward where 120 patients remained for eight days! In this particular ward, recorded temperatures of 98° and over were the common finding! Perspiring patients, attired only in pajama trousers and slippers, who preferred to sleep on blanket-covered decks rather than in their tier-bunks were more difficult to supervise than those who might have been comfortable under adequate ventilation-facilities. However, the soothing and sedative effects of a violent storm or a rough sea cannot be overestimated. Each time the vessel returned to New York, port inspectors would board the ship, note the ventilation difficulty, sagely nod their heads and agree that "something must be done," mark it down in their report as bearing an "A-priority" . . . and each time we would sail for Europe without alterations.

Neuropsychiatric patients are classified into three groups: 1-A patients are those with mental illnesses requiring locked ward supervision; 1-B are those who require supervision but not necessarily locked ward. Thus, they messed in the dining hall, and they were taken to the open decks in groups under the supervision of ward personnel trained in the management of psychiatric cases. The 1-C patients, usually the neurotic and the neurological cases, had full run of the ship and enjoyed the same priviliges as non-psychiatric ambulatory patients. With each trip, and as the non-

psychiatric casualties diminished in number, the proportion of mental cases steadily increased until the last voyage made by the writer. At that time, neuropsychiatry represented 60 per cent of the total census. Some 1-C patients were, therefore, housed on the surgical and medical services.

Each of the two lowest (open) wards had a dayroom of considerable size which patients would have liked had ventilation been sufficient, but in one, there was no air exhaust! Nevertheless, G. I. Joe will brave any hazard to gain the comforts of a table, chairs, and a deck of poker cards. Gambling is strictly forbidden in the army, and evidence of the same is based on the appearance of "money on the table." Ergo, such games as checkers and parchesi are very popular because the implements thereof serve as chips. Another disguise which enabled us to solemnly swear no gambling occurred on our service, was a box of tongue depressors which, carefully broken in pieces, served admirably as monetary substitutes.

Eastbound trips on which the *Slanger* carried German prisoners of war who had been hospitalized in the continental United States, were easier than the return voyage with American casualties. Among the Germans the ratio of disturbed mental cases was far less than that on the return trip. Furthermore, conditioned by months and years of internment in continental prison camps, the prisoners took it for granted that they were expected to police, scrub, paint, and thoroughly clean the ship . . . which they did. On arrivals in Southampton or Cherbourg our vessel was a shining picture-book reproduction of a model hospital ship! In addition, there is nothing like an American cigarette or the meaningful whisper of "Siberia!" to an eastward-sailing German prisoner to produce limitless energy and work.

The homeward voyage unfortunately witnessed the unavoidable sacrifice of the clinical for the administrative. This unfavorable balance had to be maintained at least for the first 48 hours with professional regard only for the emergency. The writer, the only trained psychiatric medical officer, and two younger, unskilled medical officers constituted the N-P staff for a unit housing about 500 patients. In addition there were 16 nurses and 30 enlisted men. All of the latter had been trained at Mason Gen-

eral Hospital, and one was a well-qualified psychologist who doubled as clerk and secretary. Considering that 30 ward men had to care for 500 patients, day and night, of whom 120 were disturbed and had to be fed from a diet kitchen on their own ward, the writer regards this ratio of 30 to 500 as insufficient. He has only the greatest admiration for these men and women who labored unstintingly in shifts of 12 hours, beneath the level of wild waves, in ill-ventilated, cramped quarters, and, on the nights of leaving and arriving, working many hours in excess of the usual 12.

Administratively, here are but a few of the items to be completed on all patients within 48 hours of embarkation: checking clothes, storing clothes in the hold, checking moneys and valuables, searching and checking hand and hold luggage, filling out individual receipts in triplicate for the articles mentioned *and* fully describing each, searching for unauthorized weapons and declarable items such as perfumes, etc., completing ward rosters, diagnosis cards, (including name, rank, serial number, organization, air corps or otherwise, state of preference, medical code number, diagnosis, ambulatory or litter, and other classification data), coordinating mess hours, arranging for the service of food out of the diet kitchen on the disturbed ward, examining patients for contagious conditions, arranging for times when ward men can make commissary purchases for patients, issuing cigaret ration cards, *et cetera.* The innumerable forms, cards, blanks, certificates, labels and tags that must be completed *by an officer* in most of these administrative matters need not be detailed.

In addition to the 120 berths on the disturbed ward, which are arranged in double-deck fashion in state rooms holding from two to four patients, there were 14 (justifiably-termed) "cells." These were originally intended as seclusion rooms, but size, heat and ventilation difficulties eventually converted them into storage chambers. Each was so small that it was impossible to place a cot in it! Its cement deck, metal bulkheads (walls) and overhead (ceiling), single, recessed, 25-watt light, and stifling atmosphere were a far cry from modern therapeutics. For want of better facilities, the passage (corridor) in this cell department was used as a combination seclusion and pack chamber which could hold from five to six patients at one time, with two corps men to supervise.

Since there always were more, of course, than a mere half-dozen disturbed patients, we were constantly posed with the problem of shifts and with making priority ratings as to which patient's disturbed condition was most demanding of immediate attention.

Belying its own connotation was the word "neuropsychiatry." Of our entire loads, the writer recalls but four neurological patients: one returning French officer with disseminated sclerosis; two cases of periferal neuritis caused by chronic alcoholism; and a German prisoner of war who, presenting nothing more than a superficial depression, suddenly suffered a cerebral reaction and was dead within 12 hours from what autopsy revealed to be a frontal lobe cystic tumor. Otherwise, all of our patients were psychiatric, covering the usual range of diagnoses expected in the military.

The therapeutic possibilities aboard a hospital ship are beyond expectations and are extremely diversified. The major shock procedures, as would be anticipated, cannot be resorted to where an Atlantic run of eight days or a Pacific trip of 18 would imply the undesired interruption of such treatment methods. Otherwise, it can be said that transport facilities rival those of permanent, land installations. The psychiatrist at sea who "has no place to go," has, therefore, no fixed office hours. I recall many pleasant and mutually profitable evenings and nights spent in personal interviews with patients, particularly with those suffering with neurotic syndromes, patients in whom marked progress and evidence of assured recovery were obvious within the short week of travel, where the psychiatric approaches of reassurance, encouragement, reeducation, distributive analysis, catharsis, etc., were anything but ventures in vain. Similarly, informal "bull sessions" with the boys invariably were rewarded with marked emotional improvement and diminution of tension. Because of the accent on informality and the deliberate avoidance of schedules and definite programs I feel that the term "group therapy," while present in deed was actually absent in name. After five years of army psychiatry I am convinced there is one prime piece of armor the therapist must wear in his conversational approach to the patient who is particularly apprehensive about his own ultimate prognosis. That approach is what I prefer to term "nonchalant conviction." Here the phy-

sician imparts the idea that recovery of the patient is unquestionable. Let us quote a sample talk between medical officer and patient:

"Doc, what gets me is this feeling I have . . . jittery, I guess you'd call it . . . I always feel, well . . . on edge . . . jumpy."

"Anxious, we'd say."

"Yeah, that's it! . . . And it has me worried . . . I can't see how I'll ever be any different."

"That's *your* professional opinion, *doctor*?"

"Heck, I know I'm no doctor . . . but have you had many cases like mine?"

"On a conservative estimate, I'd say several thousands."

"No!"

"Yes!"

"Do any of 'em get better?"

"Do they? Why I remember a lad we brought back last winter . . . I won't go into scientific detail, but I will say he was the lulu of 'em all! I considered myself lucky to get him as far as the ambulance which took him to Mason General!"

"And what happened to him?"

"A couple of trips later I learned he had recovered and had been sent home after two months in the hospital . . . After that . . ." a shrug of the shoulders.

For the average psychoneurotic patient, particularly those who were tense and suffered with sleeplessness, a single dose of a light or moderate barbiturate at bedtime usually sufficed. For the acutely disturbed, assaultive, destructive, homicidal and/or suicidal individual, the drug of choice was orally or hypodermically administered sodium amytal usually in doses double that normally given. Lacking suitable therapy beds and because of pitching and rolling of the ship, a possibly unique method of completing cold, wet packs was evolved. The patient was placed on a litter, the latter on the deck, and the pack administered. Because of the excessive heat, a wet pack would become a dry restraint in a matter of minutes. To combat this, corps men constantly kept the sheets wet with buckets of cold water.

In mechanical restraint, the camisole was seldom used because we lacked isolation facilities. Any patient placed in a camisole

would be promptly "liberated" by another patient as soon as the corps man had turned his back. Restraining sheets were used when disturbed patients were placed in the cell corridor mentioned.

However, at sea, there is nothing, I repeat, as promptly and continuously sedating and quieting as a storm, squall or hurricane. Under the influence of seasickness, the psyche seems to be the slave of the soma.

Through special services and the American Red Cross, various therapeutic adjuvants were made possible. These ran the gamut of birthday parties; organized games; motion pictures (pre-Broadway releases); Truth or Consequence sessions; vaudeville parties; dance band music and other presentations broadcast over the public address system, featuring request numbers telephoned to the bridge for patients; wood and leatherette work; painting; carpentry and other arts and crafts. The chaplain's office maintained an excellent up-to-date library while the latest magazines and periodicals, together with a daily news and ship's log broadcast were always at hand. The Red Cross always maintained a loan center where financially embarrassed G. I.'s could borrow a few dollars for commissary purchases, and free cigarettes, candy, stationery, didie bags containing pencils, playing cards, toilet articles, etc., were features of every trip.

Although the *Slanger* had an electric shock therapy machine, it was never used because construction for a therapy room, which was constantly requested, was never accomplished. However, colleagues have informed me that electric shock therapy has been found to be most desirable and useful at sea, particularly on the longer Pacific runs. Here, total recovery of the depressed and depressive-neurotic patient was not uncommon with a series of completed courses of therapy. Likewise, it has often proved to be nothing short of a godsend in managing the acutely disturbed patient, where lack of facilities and personnel make three weeks seem like three years. Such patients, receiving the usual dosage morning and aftrnoon for two or three days, usually became tractable and easily manageable for the remainder of the trip.

To bring hospital ship psychiatry up to maximum benefit and efficiency the following is suggested:

1. Adequate ventilation.

2. Cut each ship's psychiatric-berth capacity from complete filling, especially on the disturbed ward(s), to 85 to 90 per cent so that the psychiatrists have some empty berths and/or rooms in which to isolate disturbed patients, or to "juggle" the patients around where disturbances are reduced to a minimum.

3. Adequate seclusion and pack rooms; sufficiently large to permit utilization of a berth and of a chair for a corps man.

4. A shock therapy room (electric) so placed that it is adjacent to seclusion rooms which could be used temporarily for post-treatment chambers.

5. Medical administrative officers to relieve the medical officers of all administrative duties, thus enabling the latter to devote full time to clinical work.

6. An enclosed section of part of one open deck where even disturbed patients may be brought for fresh air and sunshine. Such a section would be comparable to the enclosed porches for disturbed patients in fixed hospitals.

Willard State Hospital
Willard, N. Y.

A FIVE-YEAR STUDY OF 112 WOMEN PAROLEES OF NEW YORK STATE HOSPITALS

A Report from the Vocational Adjustment Bureau

BY EMILY T. BURR

This study was made possible through the generous cooperation of the staff of the Vocational Adjustment Bureau* in New York City and the efforts of Mrs. Anna Kahn, who collected and organized the material. Careful records were kept of all bureau applicants, and from several hundred case histories of women registered during the five-year period designated, 112 were chosen for this study. The only basis for selection was that these women had previously been committed to State hospitals and, when paroled, were referred to the bureau for study and placement. One hundred and four were sent directly from State hospitals, while eight were referred from other sources subsequent to an earlier commitment to a State hospital.

Ninety-four of the 112 cases had been diagnosed by the hospital physicians as follows:

Psychopathic tendencies	18
Psychosis with psychopathic personality	14
Psychoneurotic tendencies	2
Psychosis with mental deficiency	4
Psychosis with cerebral syphilis	1
Psychoneurosis with organic nervousness	1
Psychoneurosis, hysterical type	1
Paranoia	3
Dementia præcox (type unspecified)	9
Dementia præcox, simple type	4
Dementia præcox, hebephrenic type	9
Dementia præcox, catatonic type	4
Manic-depressive (type unspecified)	16
Manic-depressive, mixed type	5
Manic-depressive, circular type	3

In only five of the 94 cases were the prognoses considered "fair." The diagnoses in 18 cases were not given by the hospital referring them to the bureau.

*The Vocational Adjustment Bureau was organized by Mrs. Henry Ittleson in 1919. It was a philanthropic social agency engaged in the study and placement of maladjusted girls.

One hundred and ten of the 112 women were sent to the bureau directly by physicians in 10 mental hospitals in the New York area. The referrals were distributed as follows:

Manhattan	54
Rockland	23
Central Islip	11
Pilgrim	9
Creedmoor	4
Kings Park	3
Psychiatric Institute	3
Bellevue	2
Hudson River	1
Hastings Hillside	1
	110
Social agencies	2
Total	112

Thirty of these patients were re-committed during their contact with the bureau. Twenty-four of the 30 were re-committed once; six were re-committed twice during the period covered by this report. It is to be noted that this study was made prior to the use of "shock" therapy which was then being applied in a very limited degree only.

Employment Prior to Hospitalization

The girls' employment experiences before their commitments to the hospitals are important and were carefully studied. In only 85 of the 112 cases, was it recorded that the girl had ever worked. It was definitely noted that of the 85, 10 had never worked, and three had been employed irregularly; but a statement regarding the specific areas of their employment was lacking. Seventy-two of the 85 were employed in the following jobs:

Clerical	21
Industrial	34
Professional	5
Personal service	12
Total	72

Employment After Hospitalization

In approximately 10 per cent of the foregoing cases, the same type of work as before hospitalization was resumed after dismissal from the hospital. Five of the persons previously employed were found to be too disturbed to be commercially employable. In some instances where the person showed fair emotional stability and sufficient skill to be employable in some line of work, immediate placement was recommended. The Vocational Adjustment Bureau counselor (Alice Bessey) attempted at all times to persuade those who required special training and stabilization to accept a plan for vocational rehabilitation. It was the general policy of the bureau toward persons whose prognoses for recovery were considered rather doubtful to arrange to have them learn to do simple tasks in an uncompetitive environment. It was early discovered that no set rules as to the time required to bring about the satisfactory adjustment of an individual could ever be determined in advance.

An inspection of the factual material regarding the employment of the members of this group, after parole, shows that 39 persons held jobs during the period studied. Thirty-one of the 39 were placed by Miss Bessey in jobs on which they remained for varying periods. There were 22 girls who obtained jobs through their own efforts, though not without encouragement and counseling from the bureau staff.

Members of the staff readily assumed the rôle of advisers and friends, and the girls accepted them as such. Many contacts were maintained for months and years. The visits of 16 girls over a nine-month period were at regular weekly intervals. Others were less regular but were nonetheless faithfully maintained throughout the entire five-year study.

It is obvious, after a survey of the stabilizing effects of these friendly contacts, that one of the most useful services that was rendered by the bureau was through this "open door" method of keeping an active interest in its clients. Especially, was this sort of friendliness appreciated by the girl paroled from a State hospital. She invariably needed continued encouragement. Often she was found to lack friends and a family who "understood."

Environmental Factors

In analyzing the home environment of the 72 women on which there was information, it was found that 41 persons could be placed categorically in the low economic group, 28 in the average group and three in the highest. In many cases, the economic stress under which the home was maintained was mentioned as a frequent cause of discord. Especially, was this true when the girl who had been hospitalized returned to the family circle and was not immediately able to assume and carry her full share of responsibility.

In those cases in which "friction in the home" was reported, the girl generally voiced, in no uncertain terms, her determination "to get away from the family, never, never to live at home again." In some instances, arrangements could be made for her to live in a dormitory. However, unless there was an understanding dormitory director this was not always successful. The distinct need for an apartment in which persons paroled from mental hospitals might live quietly under a minimum degree of supervision seemed definitely indicated as a therapeutic measure of the highest importance. Such a "haven" might well be partially subsidized by the State and would beyond question cut down the number of persons who, under present conditions, are being re-committed to the hospital as unable to make an adjustment on the outside.

In 50 cases, the physical environment was noted, and 32 homes were pronounced "adequate and comfortable," while 18 were said to be "inadequate." These terms are hardly satisfactory, inasmuch as no specific standards for judgment had been set up and the information from the social service records contained no analysis of actual home conditions.

Family Background

The emotional situation in the home was difficult to determine because of the complexity of most of the family situations. In many cases, there was no information at all, or there was only a statement to the effect that "emotional upsets in the family often occurred." An attempt has been made to present a general picture of the emotional environment as classified under the following headings:

Normal, where both parents were living and the relationship between parents and siblings was good	24
Friction between parents and among siblings	43
Separation of parents, i. e., divorce, desertion	10
Good relationship to guardian or step-parents	10
Poor relationship to step-parents	2
One parent deceased (mother)	14
One parent deceased (father)	11
Both parents deceased	9
One or both parents mentally ill	7
One or both parents alcoholic	2
One or both parents permanent invalids	2
Siblings mentally incapacitated	6

The fact that siblings or a parent suffered from mental illness seriously affected the peace of mind of 16 out of the 112 girls, while 43 reported great anxiety lest they become mentally disturbed as were relatives. The psychologist spent much time in discussing with these girls either individually or in small groups, some of the salient points that have been brought out in studies of heredity. The psychologist placed emphasis on the lack of data regarding many phases of inheritance. The importance of living wholesome, normal lives was stressed. This discussion led to talks about occupations and recreation; and the girls' thoughts were diverted into constructive channels.

The general attitude toward this problem was expressed by "Sadie," when after a few conferences with the psychologist, she said, "Thank God, I've got that out of my system. I've been haunted by the thought that I was cursed by my inheritance! I've felt that I could never escape a hopeless future! It helped drive me nuts! I'm only just beginning not to be scared any more!" Once the girl was able to express her anxieties, her tension and emotional blocking tended to be dissipated although complete freedom from worry was perhaps not wholly achieved. The desire for further discussions of this subject recurred from time to time, and an opportunity for questions and answers was always granted. Gradually such requests became less and less frequent.

This type of group therapy was most efficacious as well as time-saving, since the psychologist was thus able to answer the questions of several girls at once. Awareness that the problems of a girl were the same as those disturbing others created an atmos-

phere of good comradeship. Personal matters were often discussed freely. Love and marriage quite naturally were often the subject of conversation.

Marriage

In the hospital case histories, information in regard to the marital status of members of the bureau's group was barely mentioned or was omitted altogether. So far as could be determined, 12 of the 112 girls had been married; 10 once, two twice. In none of these marriages, was a good marital relationship indicated. Separation or divorce occurred in four cases; divorce was pending in two; "friction" was reported in the other six.

Age Distribution

The age distribution of members of the group is of special interest because of the predominance of young persons. Seventy-two of the women were between 15 and 26 years old; 21 were between 26 and 30; 10 were between 31 and 35; four were between 36 and 50; only three were over 51.

Educational Background

Since the majority of the group were young, special attention has been given to the educational background of each person not only because knowledge regarding her preparation for life was important if the bureau were to offer vocational counseling, but also because education is recognized as a stabilizing influence in the lives of all young persons.

Although it is impossible to determine to what degree job misplacements are responsible for a girl's failure to make a good adjustment, it is, nevertheless, of interest to note her school record and determine whether she has had special training of any sort. Thirty-eight were found to have attended grammar school for a time; 12 others had been able to complete grammar school. Three of the 12 undertook trade school training and four of these grammar school graduates finished a business school course. Only nine of the 46 who went to high school were graduated. One girl, who had had two years of high school, studied nursing and had a fair degree of success prior to her breakdown. After her recovery, she

was unable to resume nursing. Two high school graduates completed business school after their first parole from hospital. These girls, having a skill, were able rather quickly to obtain work for which they had been trained. Five girls had received some college education and two others had obtained college degrees before their hospitalization.

Of the 39 other girls who had had some vocational training before their commitments, although they had not completed their courses, none had been able to obtain a position in the particular line for which she had been partially prepared.

An analysis of individual cases suggests that failure in this group to complete a course was generally due to a lack of ability to assimilate the subject-matter presented. This caused a sense of inadequacy and a withdrawal from group activities, which further increased the mental symptoms that were already discernible to a few observers.

It is obvious that no definite conclusions can be based upon a survey of the educational background of so few State hospital parolees, yet it is evident that in this fairly good sampling vocational training was generally valuable since:

1. A girl who had had some specific training adjusted more readily to work than did the totally untrained girl, even though the job obtained was not in the line for which she had been prepared.
2. Girls who had completed training courses expressed satisfaction and did not show the signs of frustration and the sense of failure which were present in girls unable to finish their courses.
3. Morose and bitter self-accusatory attitudes were revealed by several who failed to get and keep a job.
4. Disappointment over the selection of the wrong vocation definitely increased anti-social tendencies and led to a withdrawal from social activities.

Recommendations for training were based on the test results, the individual's interests and abilities and the opportunities offered in industry at the specific time the girl was under the bureau's jurisdiction. The constant supervision and encouragement

given during the training period and the assurance that help in finding a job would be available whenever the course of training was completed proved extremely effective in the maintenance of morale. Referral to other agencies, when this seemed wise, was always on a personal basis. The girl's progress was checked, and she was led to keep in friendly contact with the bureau.

Aptitude tests in addition to a general intelligence test were administered in many instances in order to determine the line of work for which the girl was best suited. The Girl's Mechanical Assembly and a peg board test were found the most effective methods of measuring ability to perform different types of manual work. The five persons who rated below 50 I. Q. were found incapable of functioning in either workshop or the bureau's unit training courses. Three of the five were so mentally incapacitated that they were re-committed to the hospital. Of the 15 girls referred to the unit training courses, eight had I. Q.'s between 50 and 75; three had I. Q.'s between 76 and 90; four had ratings between 91 and 99. Of the 20 girls in the workship, six rated between 76 and 90; two, between 91 and 99; and 12 between 100 and 124

Bureau Scholarships

Besides the workshop and unit training courses, an inspection of the bureau's services to members of this group shows that special training in typing, filing, fashion-designing, and machine-operating was arranged for 27 of the 112 parolees. After the completion of their courses, even though training did not lead to immediate placements, all 27 girls showed some improvement in stability and poise and in general attitude toward life.

Because they were slow learners, the 15 referred to the unit training courses received a great deal of individual instruction. Courses in assembling, sample mounting, various types of packing, tagging, collating, pinking, operating a foot-press and a buttonhole machine proved the most successful single operations. These courses consisted of supervised exercises in which practice was continued until the quantity and quality of the girl's production equalled that of the average worker in the industry for which she was being trained. Inasmuch as most industries require workers capable of speedy performance and the uniform execution of a

repetitive task, this preliminary discipline proved to be of paramount value in preparing certain girls for active participation in industrial work.

Another method of preparation for work was made possible through the training and sheltered employment offered by the workshop, to which 20 of the 112 girls were sent. This workshop was intended primarily for girls who were handicapped by "nervousness," some personality maladjustment or a mild mental disorder but who were adjudged to be industrially redeemable. It served as a haven for girls and women paroled from State hospitals who needed occupation and cheerful surroundings and would profit by the performance of carefully selected work, suited to their several capacities. It functioned as a bridge between the hospital and a job and gave to each member of the group an opportunity to become accustomed gradually to the demands of a full-time commercial position.

Psychologically, much was accomplished for a large majority of the girls. Notations regarding their daily achievements, changed attitudes, improved appearance and increased capacity to work steadily and serenely were made. The records showed that adjustments to group activities were brought about through parties engineered by the girls themselves and that working for a common end led to the unity and harmony of the entire group.

A Few of the Workshop Problems

In the workshop new situations had to be met continually. Minor matters often caused disturbances and conflicts. For instance, ventilation aroused controversy. Opening or shutting a window without permission had to be forbidden. This ruling was essential because one of the girls, as an attention-getting mechanism, had climbed far out on the window-ledge, threatening to jump. She was delighted with the excitement which ensued. When this young woman was allotted the very important task of giving out part of the work and keeping the attendance record, she made no further attempts to gain attention. These jobs gave her prestige and satisfied her ego.

A like technique was utilized when "Elise" staged fainting spells to get sympathy. These "spells" always occurred when the

workshop director was out of the room. Because of this timing, suspicion was aroused as to the genuineness of the attacks. One day the director purposely returned much sooner than was her habit and found "Elise" stretched on the floor with several girls hovering over her. The director quickly sent for water, saying, "We'll dash it over her head." When Elise heard that, as if electrified, she sprang up, exclaiming, "Please don't. I've just had a marcel." Obviously, her fainting spell was a bid for the limelight. The psychologist then had a few long private talks with "Elise" and helped her, by a searching analysis of her personal problems, to a better understanding of herself. These talks proved so effective that there was never a recurrence of the "spells." At the same time, plans were made for "Elise" to teach new arrivals in the workshop how to sew certain articles, an art in which she excelled. Later she was assigned to supervise a doubly handicapped girl, and this too gave her infinite satisfaction. She no longer had to seek for special attention. She was contributing to the welfare and happiness of others.

There were always problem situations among members of this group, some of which involved work and the time element. A low threshold of fatigability made it difficult for several girls to remain in the workshop more than three or four hours a day so that the skills which they were learning were acquired very slowly. Infinite patience in handling the group was essential. However, the recorded reports of girls trained there justify all the expense and effort that were expended by the bureau president, Mrs. Ittleson, and her corps of volunteers.

In this brief article, only the high spots of these volunteers' efforts can be mentioned, but no reference to the workshop can be made without noting, in the later years of the experiment, Harry Frank's contributions to the development of the training methods and the clever machine-adjustments he made to facilitate production. Under the supervision of Mrs. Alda Frank, charming salable articles were devised and placed upon the market in the bureau's Madison Avenue shop and in one of the better New York department stores. The popularity of these articles made the workers very proud. The bureau's paroled girls would often go to view their handiwork on display. Such trips proved an incentive that

increased their production and inspired the cheerful attitude that comes from successful accomplishment.

Careful daily records of each girl's work and behavior were kept. These records were sometimes shown her so that she might be encouraged by the steady improvement in her output, or be spurred on to do more and better work. An inspection of workshop reports of the 20 paroled girls plainly indicates that they profited by a period of supervised training and work in a sheltered environment prior to placement in a commercial concern. Furthermore, it was found that if work was colorful, attractively fashioned and salable it had a definitely therapeutic effect. Learning a new skill was also a valuable morale builder.

The importance of accentuating training facilities in the adjustment of paroled patients is illustrated by the experience of "Mollie D.," a girl diagnosed upon her admission to the hospital as a manic-depressive case. Aptitude tests had shown her to have good motor control and the ability to increase her speed of performance with practice. She received instruction in electric-power machine operating and soon was stitching the dress hangers that at the time were the simplest article made in the shop. Her skill improved steadily, and her piece-work earnings increased until she could be placed on an outside job. Her wage leaped from $13 to $40 a week, more than she had ever earned in the hand-sewing job she had held before her breakdown. This improvement in her financial status was distinctly due to the fact that she had received training suited to her capacity and that her training had been continued over a sufficiently long period to bring self-confidence and the ability to work steadily with speed.

Her case and those of several other girls lead to the recommendation that young persons, especially those showing emotional instability, receive a complete psychological analysis early to determine their vocational aptitudes. And, after that, the training prescribed should be carried through. Had this method been followed in the early adolescence of the 112 women whose histories have been considered here some of them might not have become the seriously maladjusted persons the bureau has been trying to help.

How much members of this group were benefited through the application of the bureau techniques cannot be accurately calcu-

lated. However, an attempt has been made to measure the relative success or failure of these individuals by noting the changes in the status of each on the basis of careful consideration of the improvement shown.

The following table shows:

No improvement	30
A little improvement	40
Some definite improvement	27
A great deal of improvement	15

Those listed as having shown "no improvement" are the individuals who, unable to adjust to community life, were re-committed to a State hospital.

Described as showing "a little improvement," are 40 persons. They include those who held jobs for a maximum of only one to four weeks, and those who had only partially completed a course of vocational training. No one listed under this category had had sufficiently severe recurrence of former symptoms to warrant recommitment to a hospital. They all were emotionally unstable and were designated as borderline cases. At the conclusion of the five-year period covered by this study, 18 members of this "little improvement" group were continuing to come to the bureau at irregular intervals to discuss their personal problems.

"Some definite improvement" was revealed by 27 of the 112. These girls, it is interesting to note, came to the bureau for conferences much more regularly than those just listed. If unable to keep an appointment, a letter or telephone call explaining the reason for failure to appear was often received. An analysis of the content of such letters proved to be most helpful in the solution of the emotional problems of some of these persons. Members of this group kept the jobs to which they were referred and gradually showed an increasing ability to adjust to home and work situations. The main difficulty, which long continued to take paramount place, was caused by personality defects which led to quarrels with co-workers. Such matters were brought up for discussion during interviews at the bureau; and, at times, a frank discussion of a girl's mental attitude reduced or eliminated entirely the dissensions which might have resulted in dismissal.

In general, this "definite improvement" group includes those girls who had acquired sufficient emotional control to cope with many of the everyday problems involved in business contacts.

Of the 15 women who showed "a great deal of improvement," eight had been diagnosed as manic-depressives, five as psychopathic personalities, and two as having definite psychoneurotic trends. Their recoveries took place under the more or less optimal conditions provided by the bureau. That they were able to take advantage of the opportunities offered and had the capacity to adapt themselves to different persons and varying situations in the business and in the professional field is the bureau's justification for putting them in the category of "greatly improved."

It is obvious, even from this brief review of 112 cases, that much can be done to meliorate the difficulties encountered by girls paroled from New York's State hospitals.

The bureau's chief plea is for a program of preventive work but, inasmuch as there is a continuous stream of patients, both men and women, paroled from hospitals for the mentally ill, who need specialized training and work in a sheltered environment, it is also urged that enough unit training courses and sheltered workshops* be established to make practical vocational therapy available to the end that the individual may be helped to adjust to life and work.

Guidance Bureau

1790 Broadway
New York 19, N. Y.

*A more detailed study of the contributions of the Vocational Adjustment Bureau is in the process of preparation.

THE SELECTION OF PATIENTS FOR THE WESTERN STATE PSYCHIATRIC INSTITUTE*

With a Study of Diagnostic Agreement in the First 200 Admissions

BY GROSVENOR B. PEARSON, M. D., AND SAUL ROSENZWEIG, Ph.D.

From its opening on November 2, 1942, to April 24, 1944, the Western State Psychiatric Institute† admitted 200 resident patients. The policy guiding the admission of these patients, while still experimentally fluid, has certain outstanding characteristics which seem worthy of review in the light of this first year and a half of experience. One purpose of the present paper is to discuss the formation of admission policy and then to describe the group of patients actually admitted. The diagnoses of the patients at the Pennsylvania state hospitals from which they came and the changes in diagnoses at the Institute are also treated in some detail as a problem in nosology of independent interest. The discussion as a whole may provide some suggestions for future guidance in selecting patients.

I

The Western State Psychiatric Institute and Clinic was established to foster the interests of psychiatric and related teaching and research in Pennsylvania. The policy governing the admission of patients is, therefore, naturally different from that obtaining in the ordinary state hospital or from that in "acute" receiving wards for psychiatric patients. Since treatability is neither the sole nor even the main criterion for admission, a policy has been worked out to further the other chief aims of the Institute. Procedures have been tentatively adopted which facilitate selection after careful consideration from the broadest resources within the state. Lest the Institute become a clearing house or an acute re-

*Presented in substance by the senior author, director of the Institute, at a meeting of the Pittsburgh Neuropsychiatric Society, March 19, 1945. The authors acknowledge with thanks the technical assistance of Mrs. Jean Miller in the preparation of the tabular material.

†The original name of the Institute—in Pittsburgh, Pa.—was Western State Psychiatric Hospital but on April 17, 1945, it was officially changed to Western State Psychiatric Institute and Clinic.

ceiving center in which diagnosis and treatment, rather than research and teaching, would inevitably play the leading rôles, admissions directly from the community were ruled out. As an alternative, patients are admitted by transfer from the state hospitals throughout Pennsylvania according to the needs of the Institute and the availability of the types of patients in question. In the ordinary case, the director of the Institute makes contact with the superintendents of the other state hospitals and requests the transfer of such patients as are needed for current activities. The superintendents, in turn, submit abstracts of cases considered suitable. After a selection from these abstracts has been made at the Institute, the superintendents request permission for the transfers from the patients' relatives and then from the Bureau of Mental Health. On occasion, a superintendent may spontaneously nominate a patient who appears to offer interesting teaching or research possibilities, and such initiative is definitely encouraged.

Patients are admitted for a limited period and then, if not recovered,* retransferred. While it was the original plan to restrict residence to approximately three months, certain practical difficulties have arisen which make the average duration longer. It is, however, still the policy of the Institute to keep the period of residence brief enough to be consistent with the changing needs of teaching and research. Needless to say, there are also at times reasons for prolonging a patient's stay if the case presents complicated aspects that warrant extended investigation or if the clinical picture has unusual value for the purposes of teaching.

Since for the present, teaching plays a greater rôle than research in the activities of the Institute, instructional needs figure predominantly in the admission policy. For every variety of student —medical, nursing, psychological and social service—typical clinical pictures are of obvious value. It is, of course, always necessary to guard against specimens so exaggerated as to create didac-

*For completeness it should be mentioned that patients who improve or recover while at the Institute are allowed home on visit or are returned to the hospitals from which they came with the recommendation that visit-privilege be allowed. While the parole of patients is not the primary concern of the Institute, as compared with teaching and research, some provision had to be made for it because of the demand which arose. It can also be seen that this provision does serve a certain teaching purpose, as with social service students.

tic illusions for actual situations in subsequent practice. For medical students, early and moderate deviations from normality are particularly useful. While for theoretical demonstrations more advanced or chronic cases are equally instructive, such patients are less likely to be encountered in general practice. The psychoneurotic or the individual with a conduct disturbance, though more difficult to find in the ordinary state hospital, is, therefore, especially prized for teaching purposes. For the student nurse, features of behavior such as suicidal tendencies that might be encountered in general hospitals are of value. At the same time, it must be kept constantly in mind that the average nursing student is neither physically nor emotionally able to cope with the severely sick mental patient—one, for instance, who is desperately suicidal or extremely hyperactive. For the student of psychology, accessibility of the patient to psychological procedures is an important consideration, while for the social service student, patients who are likely to get better and leave the Institute and thus invite participation in post-hospital planning are desirable. In the last connection, nearness of the patient's home is a clear advantage.

Since research may take various directions at various times, the diagnosis, sex and age of patients to be admitted for research purposes cannot be generalized. The chief project during the period under review was devoted to factors in the breakdowns of men discharged from the armed forces on neuropsychiatric grounds. In that instance, 43 patients with the desired history were admitted—36 with various forms of schizophrenic reactions, three with affective disorders, two with organic psychoses and two without psychosis in the technical sense. The whole group represented breakdowns in the early phase of military adjustment rather than breakdowns from battle-fatigue or panic, but this limitation did not seriously affect the investigation. It resulted from the fact that veterans were received in the state hospitals—rather than in regular Veterans' Facilities—only during the early stage of the war. What ex-military patients were available were obtained from the state hospitals without difficulty. As an interesting example of the natural cooperation between research and teaching functions, it may be noted that these veterans were also of value for demonstrating to our medical students, most of whom were in army or navy re-

serve corps, characteristics of maladjustment associated with military service.

While from the foregoing it might be assumed that treatment plays no part in the policy of admission, such an assumption is, of course, quite unjustified. No patients are accepted for whom, for any reason, adequate treatment cannot be provided; and in some cases the treatability of the patient at the Institute, as compared with similar possibilities at the state hospital from which he comes, influences the transfer significantly. As in the course of time special treatment programs are set up in connection with research, the treatment criterion will naturally play an even greater rôle in requests for transfer.

Needless to say, the various functions of the Institute are closely interrelated and may be expected to remain so. Patients admitted primarily for any one main purpose inevitably serve also to satisfy the others. The same patient who exemplifies for teaching purposes some typical clinical picture may likewise take part as a subject in a research project involving the diagnostic group to which he belongs; and he may concurrently benefit from participation in some appropriate treatment program.

The theoretical aims in connection with the admission of resident patients have thus far been considered but there are also certain practical considerations which cannot be overlooked. One such consideration is the attitude of the patient's family regarding transfer. As has already been mentioned, permission from the family is always requested. In some instances, families prove to be very eager for the transfer for reasons of convenience in visiting—when the patient's home is in or near Pittsburgh—or because a great deal is expected in the way of treatment at a new institution with a relatively large staff for a small group of patients. Other things being equal, the convenient location of the patient's family is, of course, no drawback to transfer. Expectations regarding treatment, however, are frequently misleading and require correction. It is possible that in some instances the Institute is able to accomplish more for a given case than would have been done elsewhere but any guarantee of such a result can naturally seldom be given.

In contrast to those relatives who are eager for transfer are others who hesitate because the patient is well-adjusted in the state hospital where he already is, and he may be improving under treatment there; who hesitate because the Institute is farther from the patient's home; or for the reason that there would be less opportunity at an urban Institute for our-of-door exercise or for certain kinds of industrial therapy. Such reasons are, of course, cogent where they apply; and transfer in such cases is not encouraged.

Other obstacles to transfer include structural features of the hospital building, such as the lack of seclusion rooms; the danger of admitting patients who could not be adequately cared for by a nursing service composed largely of students in training; and the lack of the sizable resident staff required for acutely ill patients. While patients with acute illnesses are thus often eliminated, it is believed that for most teaching and research purposes comparatively chronic patients are satisfactory. In any event, here as always, it is necessary to balance one type of benefit against another and be satisfied, at any one time at least, with such a policy as serves the most or the broadest purposes.

The patients seen in the out-patient clinic contribute significantly to the aims of the Institute which have already been outlined. These patients are, of course, referred directly from the community. They are selected, not only to serve teaching and research purposes, but also to supplement other available community services for diagnosis and treatment.

II

In keeping with the foregoing general policy and in particular with reference to teaching, it was considered desirable to have in residence a certain proportion of patients of each general diagnostic classification. A review of the first 200 patients admitted will reveal to what extent this desideration was accomplished. The relevant data are presented in Table 1. It will be noted in examining this tabulation that instead of the more familiar specific diagnoses, certain general categories have been employed for the purposes of this survey. Under the heading of organic psychoses are included

TABLE 1. DIAGNOSES OF 200 PATIENTS ADMITTED TO THE WESTERN STATE PSYCHIATRIC INSTITUTE

	Other hospital diagnoses		W. S. P. I. diagnoses		Proportion desired for admission
	No.	Per cent	No.	Per cent	Per cent
Organic psychoses	43	21.5	42	21	20
Affective psychoses	23	11.5	37	18.5	15
Schizophrenic reactions	100	50	104	52	35
Psychoneuroses	14	7	5	2.5	15
Without psychosis	14	7	12	6	—
Undiagnosed psychosis	6	3	0	0	—
Total	200	100	200	100	

general paresis, postencephalitic sequellae, and alcoholic, traumatic, arteriosclerotic and senile conditions. The affective disorders comprise cases of manic excitement, involutional melancholia, and depressive disorders other than reactive depressions. Schizophrenic reactions include dementia præcox, paranoia, paranoid condition and, for convenience, several instances of psychoses associated with psychopathic personality. Under the psychoneuroses are found the usual conditions so classified and, in addition, the reactive depressions. The group "without psychosis" contains patients with mental deficiency and some who are suffering from conduct disturbances but not strictly psychotic. A small proportion of patients with undiagnosed psychoses was also admitted.

Table 1 shows the number and percentages of patients falling into the various diagnostic groups at the time of admission and after re-evaluation at the Institute. It will be observed that several discrepancies occurred, and these will be considered in some detail. For the present, attention may be directed to the comparison between the proportions of each group desired for admission and the numbers actually admitted. Relatively good agreement between the desired proportion and the actual is found under the headings of organic and affective psychoses. The somewhat larger number of schizophrenic patients admitted than was anticipated is readily understandable, since that category includes the perennially largest and most varied group in mental hospitals. Since, however, cases of schizophrenia are outstandingly good for teach-

ing purposes—all psychiatry can perhaps be taught from this group—the discrepancy is by no means serious. A disappointment, though not a surprising one, is the small number of psychoneurotic patients received. The fact is readily explicable from the well-known lack of such cases in the average state hospital unless the patients are so severely ill as to be, for practical purposes, psychotic. It was, however, particularly gratifying that a fairly large number of patients "without psychosis" were admitted, since they, like the psychoneurotics, are rare in state hospital populations. It should be observed that the six patients admitted with undiagnosed psychoses naturally play no part in the comparison. The comparison as a whole clearly indicates the excellent cooperation that the Institute has received from the contributing state hospitals.

Brief mention may be made of the status at present writing of the 200 patients under review. Of the total number, 36 have recovered sufficiently to be sent home. Of this group, six were fully discharged on leaving the Institute; 18, at the expiration of about a year's visit; and the remaining 12 are still on visit. Of the 30 patients last mentioned, it is of interest that 17 belong in the schizophrenic group. On the negative side of the ledger are five deaths. One mortality resulted from bronchial pneumonia in a patient with Huntington's chorea; another from pulmonary tuberculosis complicated by generalized arteriosclerosis; a third, from aleukemic leukemia in a schizophrenic patient; a fourth, from tuberculous pneumonia in a case of involutional melancholia; and the last from cardiac decompensation and bronchopneumonia in a paranoid patient. Of the remaining 159 patients, 109 have been re-transferred, and 50 are still at the Institute.

III

It is with considerable justification that present emphasis in psychiatric teaching is upon disorders of function rather than on diagnosis. From the standpoint of the student, the modern trend is entirely logical, since psychopathology is obviously more important for most constructive purposes than the assignment of labels. However, the determination of a working classification has certain indispensable values from the administrative standpoint. The diagnosis is, after all, the hospital's shorthand for many practical prob-

lems connected with the disposition of a case. From such labels, however inadequate, clues to prognosis and treatment are usually available and these advantages cannot be overlooked. It is accordingly of interest to consider in some detail the diagnoses of the 200 patients under review at the time of admission to the Institute in comparison with their classification after residence had afforded opportunity for further study.

Beginning some 30 years ago, a series of papers dealing with agreement in diagnosis was published from the Boston Psychopathic Hospital. That hospital is essentially a clearing house for acute cases received directly from the community and sent on, if necessary, to the various state hospitals in Massachusetts. The agreement investigated was that between the diagnosis assigned at the Boston Psychopathic Hospital and that given subsequently at some one or another of the state hospitals. Southard and Stearns,[1] in the first of these studies, found a disagreement of 36 per cent, but about five years later Lowrey[2,3] reported a 26 per cent discrepancy. In a later investigation, Wilson and Deming[4] found a higher percentage of divergence—42 per cent. They believed that the greater disagreement in their study represented in part the influence of new and divergent psychiatric schools then current. While they were unable to answer the question as to how much discrepancy in diagnosis might be reasonably expected, they showed that the degree of diagnostic consistency in psychiatry was at least as good as that found in internal medicine. Wilson[5] subsequently pointed out that disagreements in diagnosis may be attributable to the fact that, after a relatively long period of observation in a state hospital and with the greater opportunity for additional social history thus afforded, there might well be reason to expect certain changes in the original classification. He further maintained that with the passage of time, psychiatric patients often develop different clinical pictures from those seen earlier. Finally, Alice Raymond,[6] working on the same problem, reported a discrepancy of 38 per cent. The figures for disagreement in diagnosis in this series of studies thus range from 26 per cent to 42 per cent.

The present comparison of diagnoses made at the various state hospitals in Pennsylvania and those subsequently given at the Western State Psychiatric Institute, while essentially similar in

purport to the investigations of diagnostic agreement just reviewed, derives from a somewhat dissimilar setting. In the Massachusetts situation, the first diagnosis was made at a clearing house, with relatively little available time and information; the second, at a state hospital where longer and more careful study was possible. Our comparison begins with a first diagnosis at the state hospital having the advantage already mentioned, and proceeds to a second diagnosis assigned at an institute under even more advantageous conditions. Under the circumstances one might expect to find less disagreement in our comparison than occurred in the Massachusetts studies.

In Table 2 are shown the number of state hospital diagnoses of each general category which were subsequently changed at the Institute. Changes in diagnoses which left the group category unaltered, e. g., from one organic type of psychosis to another or from one subtype of dementia præcox to a different one, are treated as insignificant, whereas changes from one main group to another are regarded as significant. It is the percentages of such significant changes in each group and in the population as a whole which deserves serious consideration. It will be seen that the agreement in the organic psychoses is relatively good, since only 13 changes were made in the group of 43 patients admitted under that heading; and, of these alterations, only five, or 12 per cent, were significant. In the group of affective psychoses, there was a total of 11 changes of which four, or 17 per cent, were significant. Here, again, the proportion of noteworthy change is not great. In the group of schizophrenic reactions, an even smaller proportion (8 per cent) of significant alterations occurred, though a very large percentage of the diagnoses were modified as to subtype. It is not difficult to account for the latter changes, since dementia præcox patients notoriously shift from one subclassification to another, even in a relatively short time. The psychoneuroses showed the highest percentage of significant change—79. In other words, 11 of the original 14 patients with this diagnosis were reclassified in an important way. It would appear from these figures that the psychoneurotic diagnosis, being relatively infrequent in state hospital practice, is subject to the greatest error—if, that is to say, it can be assumed that the diagnosis at the Institute is the more accurate one.

TABLE 2. STATE HOSPITAL DIAGNOSES CHANGED AT WESTERN STATE PSYCHIATRIC INSTITUTE

		Number changed in group	Number of significant changes	Percentage of significant changes in group
Organic psychoses (43)		13	5	12
To other organic types	8			
To affective psychoses	2			
To schizophrenic reactions	3			
Affective psychoses (23)		11	4	17
To other forms of affective psychosis	7			
To schizophrenic reactions	3			
To psychoneurosis	1			
Schizophrenic reactions (100)		44	8	8
To other forms of schizophrenic reactions	36			
To affective psychoses	8			
Psychoneuroses (14)		12	11	79
To other forms of psychoneurosis	1			
To organic psychoses	2			
To affective psychoses	6			
To schizophrenic reactions	2			
To "without psychosis"	1			
Without psychosis (14)		6	4	29
To other forms of "without psychosis"	2			
To organic psychoses	2			
To schizophrenic reactions	2			
Undiagnosed psychosis (6)		6	6	100
To affective psychoses	2			
To schizophrenic reactions	2			
To psychoneurosis	1			
To "without psychosis"	1			
Totals		92	38	
Total percentage of significant changes in 200 admissions				19

The group without psychosis showed relatively minor changes (29 per cent), though this figure is greater than the corresponding ones for the first three groups discussed. Since the patients admitted under the heading of undiagnosed psychosis were all diagnosed at the Institute, this classification was significantly changed in 100 per cent of the cases. The meaning of the change is, however, obviously different from that attaching to change in other groups. If the 200 patients admitted are considered in their en-

tirety, it is found that 92 changes in the original diagnoses were made but that of this number, only 38, or 19 per cent, were significant. If the changes in the diagnoses of the patients admitted with undiagnosed psychosis are allowed for, the figure for unequivocally significant changes in diagnosis drops to 16 per cent. As compared to the figures previously reviewed for disagreement between diagnoses at the Boston Psychopathic Hosital and at other state hospitals in Massachusetts, these figures are low and accord with the expectation discussed in the foregoing.

In itself, the present finding reflects altogether favorably upon the accuracy of the diagnoses with which patients were admitted. That certain alterations should have been made at the Institute is to be expected since it is by design devoted to the intensive study of a small number of patients and is staffed and equipped accordingly.

IV

The present survey of general policy regarding the admission of patients and the findings as to the diagnosis of patients actually admitted during the first year and one-half of the Institute's existence reveal that, on the whole, the procedure for selecting patients has worked with a higher degree of efficiency than could well have been anticipated in these generally troubled times. Such suggestions as emerge from the study for the future selection of patients are rather general in nature. The teaching needs of the Institute promise, for the immediate future, to maintain their predominance over research. For instructional purposes, a greater number of psychoneurotic patients would be highly desirable if patients so diagnosed accurately could be found. Of similar advantage, would be a greater number of acute cases though, as has already been pointed out, there are distinct practical limitations to the admission of such patients.

As, in the course of time, the research activities of the Institute increase in scope, certain features of the admission policy will inevitably be adapted to this trend. As research on special types of treatment is instituted, the treatability of patients will become a more important criterion for admission than has been true hereto-

fore. As regards all the functions of the Institute, the policy determining the admission of patients is on an experimental basis and open to progressive change as new experience dictates.

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A REJECTED CHILD: PROBLEMS, TREATMENT AND OUTCOME

BY MARGARET E. SPARLING, M. A.

An atmosphere of security is essential to happiness and normality in adulthood, and even more so in childhood. If a child is deprived of this in his impressionable years, behavior and personality difficulties often develop. What an adult becomes is largely determined by the experiences and attitudes he meets in the process of growing up; and, in childhood, is laid the foundation on which stability or instability, adjustment or maladjustment is based. The preschool years are of supreme importance, and here parent-child relationships are responsible for molding a child's personality. A feeling of security depends on harmony within the home, a stable environment and happy parent-child relationships. Deprived of these, a child will reflect his dissatisfaction in abnormal ways. A child's feeling of insecurity usually reflects an attitude of hostility or rejection on the part of the parents toward the child; the child either consciously or unconsciously realizes he is not wanted.

Studies have been made on maternal rejection and overprotection and the part they play in developing personality maladjustment. Kanner (1935) gives clear-cut examples of children displaying abnormalities reflecting poor relationships within the home, and says: "It is only natural that the home looms first and foremost among the situational factors which contribute to the moulding of the child's personality," and that "early home influences contribute a great deal towards the mental development of the individual." Newel (1934, 1936) in his studies on maternal rejection, says that children in situations of rejection feel insecure, and attempt to counteract this by getting from their parents, in abnormal ways, attention, and some of the feeling of importance that they should normally have. "They derive a certain satisfaction from having their mothers upset about them, and much of their specific behavior represents a discovery on their part of what their mothers fear the most." Childers (1935) feels that hyperactivity with its concomitants of desire for attention, cruelty, etc. is, frequently seen in children coming from homes where they feel they are unwanted.

Levy (1937) talks of "affect hunger," and feels that a child who is being emotionally starved through rejection, will compensate, in trying to make up for this loss, by various abnormal types of behavior, in which are sometimes threats to the life of the mother who has deprived him of her love. Symonds (1939) states that studies of rejection indicate that if a child comes from a home where he is rejected, he is "likely to be characterized as aggressive, rebellious, hostile, jealous, attention-getting and hyperactive." Rosenheim (1942) in depicting the "Character Structure of a Rejected Child," says that children who have been deprived of their birthright of love, never themselves learn to love, show a lack of responsiveness to others, and lack of ability to establish satisfactory interpersonal relationships. The Smith College Studies (1932) and others (Bender, 1943) report that aggression, rebellion and homicidal and suicidal threats frequently accompany rejection by parents with its resulting insecurity. In summing up these studies, one may conclude that, as Louttit (1936) says, "Among all the factors pertinent to the development of personality and conduct, those associated with the home are of supreme importance." And one may well feel that hostility toward and rejection of a child by his parents are responsible for many abnormal reactions in children referred to various child guidance clinics, and other agencies dealing with the problems of childhood.

This study aims to present one example of a child who was a victim of insecurity through rejection, to discuss her problems, their origin, and the method used in dealing with them.

Case History

Patient's Behavior

A five-year-old girl, who was showing numerous markedly abnormal behavior reactions, was referred to the Ontario Mental Health Clinic, London, Canada. Out of approximately 800 cases seen by the clinic that year, and 9,000 cases seen since it was organized in 1930, this is one of the most outstanding examples of children's behavior and personality disorders; and it presents a clear-cut picture of how poor parent-child relationships, specifically parental rejection, produce abnormalities of behavior and

attitude. The child's stepmother who brought her to the clinic had been asked to record the various complaints she had concerning the girl; and following is the list she submitted in her own words:

"1. She plays with herself, and her cheeks become very flushed (masturbates continually).

"2. You have to repeat everything to make her understand.

"3. She will not take a bath in a bathtub.

"4. If you ask her to hold her arm up a minute, she don't know enough to drop it.

"5. She takes three-quarters to one hour to eat her breakfast and longer for lunch and dinner.

"6. If allowed to, she will eat till she can't hold any more, then vomit it up in her plate.

"7. She will not mind anyone.

"8. She does not play with her toys or the children like she should.

"9. She will mess and wet on the floor whenever she wants to, but does not do anything in bed.

"10. Whenever you try to make her mind you, she bites and kicks you.

"11. She says: 'I don't like you, and when I get bigger I will kill you.'

"12. If given a spanking, or she falls outside and hurts herself, she never cries.

"13. In September, when the baby was only three weeks old, my mother and I were outside in the garden and he was asleep in his buggy in the kitchen; she covered him up with two woolen blankets and he started to cry. When we came in he was all black. We looked after him and then asked her why she did it. She said: 'I don't like him and I don't want him here.' We told her never to do that again as it would hurt the baby. She said, 'I don't care.' A second time she did the same thing. The third time she abused the baby, she fed him a whole radish, a red elastic band and cigaret papers.

"14. When she attends Sunday school, she won't sing what they want her to—she sings 'Happy Birthday.'

"15. She does not talk right, using her own words instead.

"16. If you give her something to take over to someone, such as an envelope, she holds it right up in front of her.

"17. When asked anything, she doesn't answer, just stares.

"18. She eats garbage, and drinks out of any old bottles.

"19. When cold in the winter, she lays down in the snow until you go and get her.

"20. She has no fear of anything.

"21. If she gets a pair of scissors she cuts up dresses, curtains, etc.

"22. She will go any place with anyone strange.

"23. She will wet in her dishes when playing with them, and she will drink it."

In addition to the foregoing, Sally herself, who talked readily of her difficulties, declared that her mother and daddy didn't like her, and she would like to go to live some place else. A neighbor of the family felt that the child was "starved for love." Sally showed a vivid imagination and took delight in making up fantastic stories. It was reported that she indulged in tantrums if asked to do anything.

Patient at Clinic

During the examination at the clinic, Sally did not show any of the characteristics or personality abnormalities described, but was pleasant, agreeable and of an exceedingly friendly disposition. On the Stanford-Binet test for intelligence she was found to be of normal intelligence: chronological age, five years, five months; mental age, five years, two months; intelligence quotient, 95. This ruled out the possibility of mental defect, with which problems such as these are sometimes associated. During the test, she was responsive, attentive and cooperative; her effort was good, and she expressed herself with surprising clarity. She seemed to like the attention she was receiving, and her behavior and conversation showed an attempt to win the kind of praise and commendation from the examiner which was lacking at home. The physical examination, which was essentially negative, excluded the possibility of postencephalitis or an organic brain condition as the basis for the child's difficulties.

Though it is recognized that constitutional trends may have some effect on personality make-up, it is felt that a favorable environment may prevent the development of abnormalities, whereas an unfavorable environment may mean their aggravation. Behavior difficulties in childhood generally reflect difficulties in the surroundings. It was necessary to look into this child's home situation and background. These were found to be far from desirable, and had led to a feeling of resentment on the part of the father and stepmother toward Sally.

Background: Parents and Relatives

Sally's father and mother, married when both were 23 years of age, came from the same community and had known each other for some time. There were no adverse comments made on the father's mental stability. Sally's maternal grandmother had died when Sally's mother was six years old, leaving the child to be raised by her grandmother who was reported to be a religious fanatic, and a father who was reported to be somewhat "peculiar." Before his marriage, Sally's father had left the district where he was brought up. Five months after his departure, he received a letter from the girl, saying that she was pregnant and insisting that he was the father of the expected baby. He returned home, and, because he wished to avoid any publicity or disgrace to his family, married the girl, in spite of the fact that he did not care for her and felt in his own mind that he was not the father. Subsequently, the child was born; and a few months later the mother began to seek the company of other men and neglected the baby. Her behavior only served to increase the father's doubts as to the parentage of the child. He found he could not live with his wife, became discouraged and moved back to his parents' home, taking Sally with him. He remained there for a year, then moved from the district, leaving the child in the care of his parents.

Environment at Five Years

When Sally was three years old, the father obtained a divorce. He remarried later that same year. He had known his second wife, Sally's stepmother, for a short time prior to his first marriage. Following their honeymoon, the newly-married couple had

taken Sally, who supposedly was the father's child, to live with them. About a year later, a boy was born; and though some of Sally's problems centered around her feelings toward this child, other difficulties had been present preceding his birth. Therefore, though jealousy increased and aggravated some of the problems, or was itself caused by them, it was not responsible for their advent.

Sally had come to this home with a history of instability of environment behind her. She had been moved around a great deal, deprived of father and mother until she was over three years of age, and left in the care of somewhat mentally eccentric individuals. However, she seemed to have been happier with them than in her new environment, as she was continually expressing the desire to be sent back. With this background of instability, Sally now found herself in a situation where the mother was not her own mother, and the father was not certain that he was her father. From the beginning, he had resented the behavior of his former wife, and this resentment carried over to her child. The stepmother conscientiously tried to do her best at the beginning of her marriage, but soon she too became resentful of this child, who, in their family physician's opinion was well on the way to breaking up the home. He sympathized with the "parents," but he also felt it was a hopeless situation for the child because of the parental problem and their feeling of resentment toward her. Sally herself had felt this resentment and lack of affection toward her, expressing her feeilngs by threats to kill her stepmother when she "got bigger." Her behavior was felt to be in the nature of a spite reaction against her father and stepmother, and a bid for the attention and security which were lacking.

Treatment and Results

The father and stepmother had gone to the Children's Aid Society expressing the desire to have the child adopted. Threats to children to have them sent away, or the act of turning them over to an outside authority, are often the overt expression of rejection and resentment (Symonds, 1939). The society in turn referred Sally to the Ontario Mental Health Clinic and requested the stepmother to supply the list of complaints of the child's behavior

already enumerated. It was felt at the clinic that the little girl would have a much better chance of adjusting if she were placed in a good foster home. Consequently she was made a temporary ward of the Children's Aid Society, a wardship which lasted for five months. During this period, Sally showed no signs of her abnormal reactions, and the foster mother with whom she was living had no complaints to make about the child's behavior. During this period, according to reports, she showed complete recovery. The matter of permanent wardship by the Children's Aid Society was taken up in court. Since to all appearances Sally at that time was a normal, well-adjusted child, the court held that it was the responsibility of the father and stepmother to make the necessary adjustments for her happiness, and consequently she was returned to them. Sally herself did not wish to return home, saying she much preferred her foster mother and father.

One week after her return home, Sally and her stepmother again came to the clinic. Back in her former environment, where the child felt she was not wanted or loved, the old problems and complaints reappeared, and the stepmother stated that there was no improvement, and that the child's actions were the same as formerly. She took things from the baby, and slapped him, probably realizing this would mean attention, though of the undesirable type, at least attention, from her stepmother. She would not eat, and, if denied anything, would bite and chew as before. Since her return, she had continually tried to make her way back to the foster home. It was felt that many of Sally's problems showed a schizoid trend, and though serious enough then, if allowed to persist, would definitely endanger her future mental health and stability. Consequently, with all this in mind, Sally was made a permanent ward of the Children's Aid Society and was placed for legal adoption.

Some time after this placement, Sally, accompanied by her adoptive mother, visited the clinic. The latter reported that Sally had a lovable personality and was not hard to manage. She was gradually getting rid of the bad habits she had had at the time of placement, and was getting on well in school. The only complaint the adoptive mother expressed was that if one spoke crossly to Sally

she would back away as if terrified. On the whole, the child was adjusting happily, and the new parents would not part with her. Sally was seen from time to time by the clinic personnel during the probationary period of two years before she was legally adopted, and these parents expressed nothing but complete satisfaction with the girl and her behavior.

Sally was seen again recently, three and one-half years after her adoption, when a visit was made to her present legal home, at which time she was 12 years of age. Again, nothing but fondness was expressed for the child, and the adoptive parents were extremely high in their praise of her. Her school teacher was also visited, and he said that Sally was one of his "better" pupils as far as her behavior and personality were concerned; she mixed well with others and had friends. She was a good worker and was no problem of any kind. Her report card showed behavior, attitude and personality checked with "A's" and "B's." Her actual school progress was not outstanding but was reported generally satisfactory.

In the years following Sally's first referral to the clinic, she has developed into an attractive, spontaneous, vivacious girl with a very pleasant personality. Now, she seems secure and wanted, and there has been no recurrence of the former complaints expressed when she was in an environment where hostility and resentment toward her were evident, and when she portrayed definite abnormal symptoms on the basis of insecurity, with accompanying instability and eccentricity in personality and behavior.

Summary

This study has presented an example of insecurity with its resultant behavior and personality difficulties. This feeling of insecurity had as its foundation, resentment of a father and stepmother toward a child of five years, followed by rejection overtly expressed in their desire to place this child for adoption. Despite a somewhat unstable hereditary background, she adjusted well in new environments, and now is a happy, satisfied, responsive girl of 12 years of age.

Conclusions

Although it might be argued that this child's problems originated in the fact that for the first few years of her life she had an inconstant physical environment, one, nevertheless, feels safe in concluding that it was the attitudes of resentment and rejection shown by her father and stepmother, that were the basis for her personality and behavior abnormalities. This is supported by the fact, that once removed from this unfavorable environment, even though permanence of the new environment was not assured, her problems nevertheless disappeared because of the marked difference in the adult attitudes toward her. Once she felt she was not rejected, but was wanted, her sense of security and resulting stability were established. It is reasonable to assume that there was the possibility of a more malignant outcome in this child's mental condition, had she not been removed from the unfavorable environment of her early years.

In its broader aspects, this study bears out what has been expressed by previous studies referred to earlier in this article, that feelings of security and stability are fundamental to the development of a well-adjusted individual; and that faulty parent-child relationships, specifically rejection, are responsible for a child's feelings of insecurity with accompanying emotional, personality and behavior disorders.

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START OF HUGE BUILDING PROGRAM FEATURES ACTIVITIES OF NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

The start of a huge construction, reconstruction and modernization program by the New York State Department of Mental Hygiene is one of the outstanding occurrences in the field of American psychiatry since the fighting in World War II stopped. At the close of 1945, the Department had asked for approval of nearly 300 construction projects to cost in excess of $130,000,000; about 100 have already been approved at a total estimated cost of $65,000,000; work actually in progress at present ranges from renovating and repairing, which had to be neglected during the war, at virtually all of the Department's institutions to extensive construction now well under way at Craig Colony to relieve one of the worst conditions of overcrowding in the State.

With the expectation that the army will soon return, to the Department, Edgewood State Hospital and other facilities leased to the government, considerable expansion of the State's facilities for the care and treatment of the mentally deranged and the mentally defective is anticipated well in advance of the opening of the new buildings of the construction program. Standards of both care and treatment have already improved over those of the war years, with the return of many of the Department's physicians who were in the armed services; some of the institutions now have full medical staffs for the first time since medical corps reserve officers were called into the service before the attack on Pearl Harbor in 1941. Occupational therapists, social service workers, nurses and other members of the professional services, as well as numerous non-professional employees have also been returning in considerable numbers. Many who left for civilian federal employ or for war work have also returned.

The prospects for relief are now plain enough so that the Mental Hygiene institutions of the State are already offering some increased facilities to the public. Commissioner Frederick MacCurdy, M. D., of the Department recently announced that the State schools for mental defectives and Craig Colony for epileptics would now admit urgent cases of defective and epileptic children under five years of age, previously excluded except for exception-

ally disturbing cases during the emergency of the war years. For the time being, only cases judged the most urgent by Department investigators will be admitted; but the Department hopes to provide special buildings for the hospitalization of more than 500, in the course of the building program; including a children's hospital for 200 infants under five at the Willowbrook State School, where pressure for admissions from New York City will be severe, three for 100 each at Rome and Newark State Schools and Craig Colony, and a unit for 40 at Wassaic State School.

Analyzing the Department's situation as relating to mental defectives, Deputy Commissioner Arthur W. Pense, M. D., pointed recently to the wartime decrease among higher-grade institutional patients, noting that morons had been able to hold many jobs during the labor shortage which they might not keep during the lesser employment of peace, and that the Department must be prepared for more admissions of this class. The percentage of morons in the patient population fell from 53.9 in 1934 to 40.7 in 1943, a war year. During the same period, the percentage of admissions of children under 10, very few of whom were under five, rose from about 25 to 32, the figure for the fiscal year ending March 31, 1943.

The Department is planning more intensive research, more psychiatric study and improved general medical care in the institutions for defectives. Dr. Pense, discussing other desirable improvements, lists more gymnasiums, more club room space and larger playgrounds among them.

Increased opportunities for advanced training of medical officers and increased research activities in psychiatry and neurology have been planned by the Department. Some of the training courses were under way in January of this year, notably one in encephalography at the Psychiatric Institute; and others are about to begin. One hundred physicians, to be added as residents to the staffs of all the State hospitals and State schools, are to attend special courses one day a week for 48 weeks at the Psychiatric Institute and the Syracuse Psychopathic Hospital, the instruction covering lectures, clinical conferences and laboratory work in neuroanatomy, neurophysiology, neuropathology, clinical psychiatry and neurology. Supplemented by supervised clinical work at the students' own institutions, this course will meet the basic require-

ments of the American Board of Psychiatry and Neurology. It is primarily intended to attract medical officers returning from the armed services; but other junior staff members than veterans may be designated by directors to attend. Directors have been advised that new residents who are to take these courses should agree to remain at their institutions for two years, during one of which each physician will be registered in the course either at the Psychiatric Institute in New York or at the Syracuse Psychopathic Hospital. Some 50 instructors, including outstanding authorities in their fields, will conduct these courses.

More advanced courses will include the usual 10-week postgraduate course in neurology and psychiatry next fall at the Psychiatric Institute for supervising psychiatrists, a four-month training program for two assistant directors (clinical) at the Institute starting next fall, and a training program which is to start next September for assistant directors (administrative) one afternoon each week at the Institute and in Albany. Finally, a more liberal policy of leaves to medical officers for study or research is projected if the return of staff members from the services and civil service regulations make it possible.

Improved care and treatment for the institutions' patients will result from the building program now under way. New medical, surgical and reception buildings are planned for hospitals where present facilities are inadequate or outmoded. Old-fashioned operating rooms, some of them referred to by the physicians using them as historical curiosities, will be replaced by modern construction and equipment. Employees, of course, as well as patients, will benefit from this advance.

In the field of physical disease, the entire Department will benefit from the construction of four new special units for the treatment of mental patients with tuberculosis. These will permit the closing in some institutions of special tuberculosis wards which had to be set up in buildings not planned for the purpose and in which it has been difficult to assure adequate segregation, take adequate measures for sanitation and carry out other procedures followed in the tuberculosis hospitals operated by the State Department of Health. Intensive study is to be carried on jointly by the Departments of Health and Mental Hygiene in reference to shock therapy

in tuberculous patients; physicians trained in tuberculosis will be assigned to the new institutions; and plans for the training of Department pathologists on the special pathology of tuberculosis are under active consideration.

In community and out-patient service, the Department not only plans to resume and expand the hospital clinics largely suspended during the war emergency but is planning specifically to meet the problems of the returned veteran with psychiatric disabilities, by offering advice and treatment and by cooperating with various other public and private social welfare agencies.

Community educational efforts, largely reduced during the wartime emergency, are being expanded as medical staff members return. *Mental Hygiene News,* an educational publication for personnel, lay and medical, of this Department and for interested outsiders, is being expanded. Its publication has been irregular, of late, because of wartime difficulties; and it may take some time to restore it to regular schedule; when this is done, it will also be improved in both content and format. Other plans to further public acquaintance with mental hygiene and promote general knowledge of the work of the Department are under consideration; and it is expected that this activity will be more effective in the future than ever before.

THE PSYCHIATRIC QUARTERLY SUPPLEMENT has become an educational publication also, of which this issue is the first example. It is to be educational in the sense that "The Psychoanalytic Review" describes itself as an educational journal; that is THE SUPPLEMENT will present discussions of psychodynamic and psychiatric subjects designed to interest or enlighten persons already familiar in general with the psychiatric and mental hygiene fields but not necessarily psychiatrists, although it is expected that psychiatrists will find it as interesting as other readers. It will be open to articles of interest from any informed psychiatric point of view. In addition, it will continue to present papers of administrative interest and technical papers in the psychiatric field which are chiefly of interest to other workers than psychiatrists.

Many of the other regular publications of the Department have been revised, enlarged or modernized. The old "Handbook" now appears in three separate sections, the "Official Directory," to

which an alphabetical index of proper names and some short tables concerning the operations of the Department have been added; "The Mental Hygiene Law and Related Statutes," somewhat enlarged from the old section of the "Handbook" covering this subject; and the "General Orders." The "General Orders" are now printed with blank pages upon which changes can be noted, and the book includes a list of the forms used in the Department and a condensed form of the latest revision of the classification of mental diseases, and an index. It will eventually be possible to keep the "Official Directory" practically up to date as well as the general orders, by use of the reports of changes in personnel which are now printed in *Mental Hygiene News* instead of THE SUPPLEMENT. When these are finally organized on a regular monthly basis, changes in the personnel can be noted in the directory shortly after being made.

Recent Bi-Monthly Conferences have been concerned to a large degree with widely varying aspects of Departmental post-war planning. Out-patient clinic service to veterans, vocational rehabilitation of the psychiatrically disabled, and civil service problems connected with the return of officers and employees from the armed services have been among the matters recently discussed. The conference progroms, now covering two days, have been greatly expanded over those of the conferences of pre-war days; and there have been numerous special conferences in addition. These special meetings have included persons concerned with particular problems of treatment, administration, general service of the institutions and maintenance. Some have been held in conjunction with the regular Bi-Monthly Conferences, others conducted independently.

Among groups which have met alone or with the Bi-Monthly Conference members in recent months are the institutions' chief laundry supervisors, farmers, statistical clerks, members of boards of visitors, and special agents. An extraordinary, two-day, special Department conference was that of food service managers, dietitians and business officers at Creedmoor State Hospital last November.

The State, Commissioner MacCurdy told this conference, is committed to an elevation in feeding standards in line with present-

day concepts and practices in the science of nutrition. The conference, the first of its sort ever conducted by the Department, was arranged by Mrs. Katherine E. Flack, nutrition expert, who was named director of nutrition services of the Department by the Commissioner to improve institutional standards of diet. There were a number of guest speakers, and persons connected with food handling in other State departments than that of Mental Hygiene were invited to attend as guests. An outline-form preliminary draft of a food preparation manual which derived its material from various sources, including institution food managers, Cornell University nutrition experts and the army and navy, was distributed at this meeting. Recently, reports were asked from the institution food service departments as to suggestions, corrections or additions. Efforts are being made to improve the food of employees, as well as of patients; and the experiment of pay cafeterias is being discussed, to be operated separately from the patients' kitchens and dining rooms.

A general survey of both central Department activity and that of the individual institutions in recent months might be summarized by the term "reconversion." The Department's over-all program of new building contemplates construction at 24 institutions. It will include 16 new medical and surgical and reception units. There will be 10 new buildings for disturbed patients, 32 for infirm patients, 15 for continued-treatment patients, numerous service facilities ranging from power plants to staff residences, assembly halls and chapels, besides three special units for children and the four projects planned for tuberculous patients. Some of these structures will replace old buildings which will be razed. But extensive repairs and renovations of existing structures which will be retained are also planned. Manhattan State Hospital will practically be rebuilt, so extensive is the modernization program, and will be enlarged and retained permanently instead of being closed as had been planned.

Other institutions where much renovating and repairing has been going on include Binghamton, Central Islip, Hudson River, Kings Park and Utica State Hospitals, and Rome, Wassaic and Syracuse State Schools. The list, in fact, might be lengthened to include practically every institution in the Department.

A number of the institutions reported occurrences of unusual interest in recent months. Newark was visited by a Governor last fall for the first time in 17 years, when Governor Dewey went there after delivering an address at the Palmyra Fair. He was particularly interested in the occupational therapy department. A handmade, embroidered luncheon cloth, with napkins, which had been made by the class was presented to him for Mrs. Dewey as a memento of his visit. The New York State institutions continue to be of interest to psychiatric workers from other states in matters ranging from construction to administration and treatment. Rochester was visited recently by the Wisconsin director of mental hygiene and the Wisconsin state architect to study two of the hospital's buildings. The chief social worker of Tiffen State Hospital, Ohio, came to Central Islip last fall to study the social service organization as a model for her own hospital.

Several important changes have taken place in administrative and supervisory positions in the Department. Dr. Walter M. Pamphilon, assistant director of Willard State Hospital on leave as acting medical inspector, was named Assistant Commissioner and put in charge of the inspection service, with part of his duties in the New York office. Dr. Arthur W. Pense, assistant commissioner, was named deputy commissioner, and Dr. Newton J. T. Bigelow, who had transferred from director of Edgewood to director of Marcy and had also been acting deputy commissioner, took the new designation of acting assistant commissioner and continues to divide his time between Marcy and the Albany office. Two important administrative officials of the Department died recently, Robert P. Rickards, director of the division of reimbursement and associate attorney, on September 18; and Stuart F. Wheater, senior business officer of Gowanda, on Christmas Day. Karl Wasmuth, assistant chief special agent, was appointed director of reimbursement to succeed Mr. Rickards.

Dr. Robert M. Elliott, who had been superintendent of Willard for 30 years before he retired in 1934, died at his home in Canandaigua on October 5. Another retired Department officer, Z. Francis Shafer, who had been chief auditor of the Department for 14 years and a member of the Department staff for 45 when he retired in 1939, died at his home in Albany on December 7.

Two important vacancies in the Albany staff were filled when Miss Virginia Scullin, O. T. R., chief occupational therapist at Pilgrim, was appointed director of occupational therapy to succeed the late Mrs. Eleanor Clarke Slagle; and Arthur J. Bradley was named director of physical training to succeed James E. Simpson, retired. Mr. Bradley had been serving as recreation instructor at Newark State School.

A new position of equal importance was filled when Dr. MacCurdy named Miss Lillian V. Salsman, A. B., R. N., M. A., as director of nursing. Miss Salsman will coordinate the nursing services of the various institutions, aid in the development of their educational programs, in the improvement and maintenance of high nursing standards and in the training and supervising of ward personnel. Miss Salsman was director of nursing at Hastings (Nebraska) State Hospital when she entered the army in 1943, after which she served as an Army Nurse Corps instructor at Fort Devens, Mass., and as director of cadet nurses, Army Hospital service, First Service Command. Miss Salsman obtained her A. B. degree from Boston University, after which she trained in nursing at the New England Deaconess Hospital. Her master's degree is in administration in nursing education from Teachers' College, Columbia University; and she did graduate study in psychiatric nursing at McLean Hospital. She had served as superintendent of nurses of the famous "American Hospital" of Moulmein, Burma, and of Ring Sanatorium in Massachusetts before going to the Nebraska state service. She has made two special tours of study of hospitals in this country and Canada, a general survey for the curriculum committee of the National League of Nursing Education in 1935, and a recent tour, since her discharge from the army, of psychiatric institutions.

MEMORIAL TRIBUTE TO ROBERT M. ELLIOTT, M. D.*

BY JOHN L. VAN DE MARK, M. D.

Our friend and former colleague, Dr. Robert M. Elliott, died suddenly October 5, 1945, at his home in Canandaigua, New York. Dr. Elliott was in his eighty-third year and had been ailing for about six weeks, but was at no time confined to his bed. He was seized with a severe cardiac attack about 8 a. m., which resulted in his death three hours later.

Dr. Elliott was born in England, March 25, 1863, the son of a British newspaper publisher. He received his preliminary education in private schools in England. Following the death of his mother, he came to the United States in 1884 at the age of 21. He had relatives in western New York State and it was with them he first took up his residence in this country. I have heard him many times recount his early experiences. In fact, he took great delight in driving through the rural section of Niagara County where he was first initiated into American ways and methods. He often spoke of his introduction to American slang and how it impressed him as compared to the English with which he had been accustomed.

Purely by accident and to his ultimate good fortunate, he obtained employment with a Dr. Peter Faling, general practitioner in a small Niagara County village. He drove for the doctor and later drove with him. He soon gained the confidence and interest of his employer and was accepted as a member of the family, with the result that he took up the study of medicine at the University of Buffalo where he obtained an M. D. degree in 1890. He served a short interneship in the Monroe County Hospital in Rochester. That institution was located next door to the Monroe County In-

*It has been a long-standing custom of the New York State Department of Mental Hygiene for a friend or colleague of an institution head or department official who dies in service or shortly after retirement to prepare a memorial tribute to be read at the next regular Departmental conference. Because Dr. Elliott retired 11 years ago and the membership of the conference has changed greatly since that time, it was decided that publication of a memorial to him would be more appropriate in THE SUPPLEMENT than with the minutes of the bi-monthly conferences. Dr. Van De Mark, who knew Dr. Elliott well, was asked by the Department to prepare it.

sane Asylum and was closely affiliated with it. At the invitation of the late Dr. Eugene H. Howard, Dr. Elliott joined the staff of the county asylum early in 1891. On July 1, 1891, the county asylum became the Rochester State Hospital; and its staff, by legislation, was made the staff of the State hospital.

In November, 1895, Dr. Elliott was appointed medical superintendent of the Flatbush Division of the Long Island State Hospital which was then operating under a general superintendent. In 1900, when the organization was divided, he became the superintendent of the division located in Brooklyn, and continued to direct that institution until June 1, 1904, when he was transferred to Willard State Hospital. This latter institution he administered with great interest and distinction until his retirement on January 1, 1935.

During his long service he affiliated himself with many local and national medical societies and was the recipient of many honors from these associations. At one time he was vice-president of the New York State Medical Society, he served as president of the Lake Keuka Medical Society, and was president of the Seneca County Medical Society. For a long time he was associate professor of nervous and mental diseases at the Long Island College Hospital; and, at the time of his death, he was a life member of The American Psychiatric Association. He wrote many articles for publication and was active while at Willard in the promotion of after-care work which was originally instituted there by the State Charities Aid Association in 1906. During his administration of Willard, considerable construction was developed and in the early '30's a reception building was completed which, by request of the board of visitors, was named Elliott Hall in his honor.

Dr. Elliott was possessed of a basically attractive personality, although casual acquaintance often gave the impression of abruptness and dominance; but close and prolonged association brought to light his true character. He was kindly, sympathetic, and congenial. He was a true extrovert, he had many friends, his employees and associates were very fond of him and often consulted him in regard to their own personal problems. One of his qualtities not so well known or appreciated by many, was his sense

of humor. He had acquired a great fund of anecdotes and had had many experiences of which he enjoyed telling. He was ready of wit and a pleasant companion.

On August 29, 1894, he was married to Alzina Todd of Gasport, N. Y., who survives him. He is survived also by one sister in England, and five nephews and nieces. He was a devoted husband and a friend we shall all miss, especially those of us who knew him best.

EDITORIAL COMENT

FOR FREEDOM OF RESEARCH

The annual effort to prohibit vivisection in this State was choked off in the Legislature this year with less of a battle than usual. We note this here because of the disquieting reflection that this soft-headed attempt to hamper scientific research will certainly be made again next year and the next year. And we note it with the idea that it may be possible to do something about it.

The perennial campaign against vivisection is carried on by a relatively small but fanatical pressure group. Some of the conscious and unconscious motivation is discussed by Major Hyman S. Barahal in "The Cruel Vegetarian" in Part I of the 1946 PSYCHIATRIC QUARTERLY SUPPLEMENT. It is interesting psychopathology; and its overt manifestations are important because they are a continuing threat to the progress of medicine.

This is not written from the viewpoint of the clinical laboratory director or technician or from that of the research pathologist; but it is written on the basis of close enough acquaintanceship with these people and their work to appreciate its vast importance and in the conviction that when they report the necessity of animal experimentation they know what they are talking about. As a matter of fact, we know quite certainly that with the exception of psychotherapeutic procedures, virtually the whole of modern medicine is based on the use of the laboratory animal in tests and experimentation. And even in psychotherapy, animal experimentation has made important contributions to theory and to techniques which were developed originally by methods essentially similar to those of the laboratory but which were necessarily concerned with human instead of animal subjects. One has only to recall Pavlov's work on the conditional reflex and current extensive investigations into artificially induced neuroses in cats and dogs to appreciate what animal work may some day mean to psychiatric patients.

The question we wish to raise here is whether it would not be possible to form a loose organization of large membership—of medical people and persons whose lives have been saved or who have been restored to health as direct and demonstrable result of animal experimentation—to combat the organized efforts to hamper medical research by legislative fiat. Relatives of such persons might be included. Physicians naturally would be, as well as practitioners of related professions. There are, for example, many thousands of diabetics in the United States who would be dead today, were it not for insulin. We have it on the authority of the original workers with

insulin that this preparation could not have been developed without experimentation—vivisection—with dogs. It should not be hard to convince these insulin-patients and their relatives of the necessity for continued work of this type.

We are aware of the formation of the Friends of Medical Research by representatives of 55 interested organizations at a meeting of the New York Academy of Medicine. County committees of prominent laymen, with a physician adviser to each are being formed. It promises to be a most useful organization and one which we heartily applaud. This should be an influential body of informed persons who will be listened to with respect. But a legislator may respect a group's views and not be impressed by its voting strength; what we have in mind is the marshalling of so much voting power that legislators will no longer fear pressure groups and will no longer seek to fight this recurring menace by hiding behind the process of killing bills in committee.

How wide the popular base of the new Friends of Medical Research is planned to be eventually, we are not informed. But we suggest that it might be well if it, an auxiliary organization or some completely different organization with similar objectives were established on as wide a basis as possible. It should be possible to enroll hundreds of thousands, if not a million or more, adult New Yorkers who have the emotional and intellectual equipment to understand that they, their relatives and friends, even their domestic and pet animals, have benefited directly in the treatment and prevention of illness from animal experimentation.

As we understand it, the new antibiotics could not have been developed or their dosages determined without years of preliminary work with animals. Animals continue to be the sources from which the serums are derived which have saved millions of children's and of soldiers' lives from the diseases which once scourged childhood and the epidemics which once accompanied wars.

One would not suppose that all persons who have benefited from animal experimentation could be or even should be interested in an organization of the sort suggested here. Our mental hospitals, for example, have helped thousands of patients with the same insulin which keeps the diabetic alive. It could not, of course, even be suggested to most of these persons that they owed social remissions to experimentation done years ago on living dogs; but it could be made plain to many of their relatives; and one does know of patients who are not only fully aware of how insulin has helped them but who are ready to say so enthusiastically if not too publicly.

One would not be so naïve as to suppose that any such suggested association could be recruited without discrimination. But there would be no rea-

son to approach any and all persons with such an idea. While there was a chance of passage of the anti-vivisection bill in the 1946 session of the Legislature, physicians in private practice did not hesitate to ask persons they met as patients and their relatives to write to Senators and Assemblymen in protest against the measure. We do not think such a physician would have much difficulty, for example, in convincing parents of a child whose life had just been saved by one of the new antibiotics that it would be a good idea to join a group which aimed at assuring the continuance of life-saving research.

We believe most physicians like animals. We like cats and dogs and horses ourselves. The personality-organization of the man or woman attracted to medicine seldom includes much unsublimated sadism. But we cannot, in general, experiment with human beings. There have been numerous volunteers who have been heroes of medical history in such problems as the conquering of yellow fever, pioneering with radium, combating various deadly diseases of unknown origin. But physicians of respect for their oath, men and women of ordinary decency, cannot carry on such experiments as those in which Nazi "medical men" exposed concentration camp inmates to extreme cold and then experimented with different methods of reviving them, making the valuable demonstration, as we know, that immersion in warm water rather than cold was apparently to be preferred as treatment for freezing. Since we cannot and do not want to do those things, we must make out with animals; since we are fundamentally rather decent people, we shall employ no unnecessary cruelty toward experimental animals; and we think most lay people who combine reasonableness with intelligence can be convinced of those facts.

There are several reasons for the suggestion that laymen of good will toward medicine be invited to enroll along with the physicians in protecting research. First, as already noted, is the obvious one of numbers. The anti-vivisectionists are vociferous; many sympathetic persons who have never studied the question are impressed by their arguments; there are persons who oppose medical research on religious grounds; it is the fear of these people's votes which is likely to tempt a legislator to vote for an anti-vivisection bill, even though he is convinced it is not in the public interest. If enough laymen will simply enroll themselves on the side of medicine; numbers will obviously be on the other side; and a legislator will fear to vote for an anti-research measure as much as he may now be tempted to vote for one. Second, there is the advantage of having medicine's position represented by something much wider than a group of specialists. The uninformed person is suspicious of self-interest when a specialist argues; he also, if truly uninformed, may resent the specialist as a symbol of parental

authority; there is an emotional urge to thwart him and prove him wrong. Third, the example of the National Committee for Mental Hygiene suggests that medical and lay cooperation on a medical program can be made to work; it might even serve as a model for the organization of state and local committees for the promotion (or protection) of scientific (or medical) research. Fourth, from the point of view of psychiatry, such an organization would be educational and thus a mental hygiene undertaking in itself.

Such an organization as that here suggested need not be elaborate. Its membership fees might well be nominal, enough to pay for the printing and distribution to the members of bulletins on legislative and other matters with which they might be concerned and to maintain a small headquarters for a permanent secretary.

Finally, this whole suggestion is purposely made indefinite and off-hand. As members of a State department, we could not well undertake to promote such a plan ourselves; and we do not conceive it our province to lay out a blueprint for others. The Friends of Medical Research may or may not be interested. What we ourselves are interested in is tossing out this idea and seeing if—after others toss it around a bit—it proves worth anything as a means of fighting this perennial, ignorant and fanatical attack on the very foundation of medicine. We would welcome comment from our readers or from any others on it.

WHAT DO YOU THINK OF US NOW?

The editors invite your comment on this first number of THE PSYCHIATRIC QUARTERLY SUPPLEMENT to be issued under a new editorial policy. It was their aim to make this the most interesting and readable copy of this journal yet produced; and it is their hope that it will improve with future numbers. THE SUPPLEMENT in the past included so much material which was published chiefly "for the record" that it crowded out many papers of value and interest. Two papers in the present number, in fact, were originally scheduled for publication in Part 1 of last year's volume; but it was not possible to print them until now.

Comment on how well or how poorly we have met our aim will be welcome. Editors of most general publications know that most readers feel they could do much better jobs if they were only the editors themselves; if some readers of THE SUPPLEMENT have similar opinions, we, as scientific editors, will not resent even sharp criticism. There are many questions involved in the revision of an editorial policy. Who are a publication's present readers? Who should naturally be its readers? We think those who

might be expected to be interested might be described broadly as all persons directly concerned, not with hospital plant, business office and upkeep, but with the care and treatment of mental patients, such as psychiatrists, nurses and student nurses, occupational therapists, physiotherapists and social workers. We know that many attendants are sincerely interested in their patients and their work and that many members of the secretarial group must give thought to the significance and interpretation of the technical material they transcribe. We hope THE SUPPLEMENT will contain articles which they will want to read also.

At present, we could answer some of our current questions better if we had some help in the answering. Are our papers in general too technical, or not technical enough, are they too wide or too narrow in range of subjects treated? Is enough or too much space devoted to this subject or that? In what ways can we make this more of an educational journal, more of a journal to increase general knowledge of accepted theories, principles and practices among all connected with our work—and among other intelligent persons interested in our work? Can we employ it usefully to further mental hygiene, prophylaxis against disorder, rather than treatment? Finally, are we going about it in the right way to keep members of our Department well-informed about developments concerning them and still produce a journal which will be primarily one of general interest, written for all workers in our field rather than solely for those in our own State service?

No editor accepts even all the undoubtedly good advice he receives. But it is important to receive it, weigh it, and then assess possibilities. Two very helpful suggestions from contributors were accepted in advance of the publication of this issue. If comments seem to the editors to warrant publication as "letters to the editor," it is planned to publish them. The directors of our institutions have had regular opportunities for open forum discussions of their problems at the Department's bi-monthly conferences; other groups have had similar open forum discussions at special or regular gatherings. But there has been no common meeting ground for our personnel in general. Perhaps there is no demand or need for one; but, if there is, and if space permits, a "letters to the editor" department might provide a place for joint discussion, by all interested, of our professional problems.

authority; there is an emotional urge to thwart him and prove him wrong. Third, the example of the National Committee for Mental Hygiene suggests that medical and lay cooperation on a medical program can be made to work; it might even serve as a model for the organization of state and local committees for the promotion (or protection) of scientific (or medical) research. Fourth, from the point of view of psychiatry, such an organization would be educational and thus a mental hygiene undertaking in itself.

Such an organization as that here suggested need not be elaborate. Its membership fees might well be nominal, enough to pay for the printing and distribution to the members of bulletins on legislative and other matters with which they might be concerned and to maintain a small headquarters for a permanent secretary.

Finally, this whole suggestion is purposely made indefinite and off-hand. As members of a State department, we could not well undertake to promote such a plan ourselves; and we do not conceive it our province to lay out a blueprint for others. The Friends of Medical Research may or may not be interested. What we ourselves are interested in is tossing out this idea and seeing if—after others toss it around a bit—it proves worth anything as a means of fighting this perennial, ignorant and fanatical attack on the very foundation of medicine. We would welcome comment from our readers or from any others on it.

WHAT DO YOU THINK OF US NOW?

The editors invite your comment on this first number of THE PSYCHIATRIC QUARTERLY SUPPLEMENT to be issued under a new editorial policy. It was their aim to make this the most interesting and readable copy of this journal yet produced; and it is their hope that it will improve with future numbers. THE SUPPLEMENT in the past included so much material which was published chiefly "for the record" that it crowded out many papers of value and interest. Two papers in the present number, in fact, were originally scheduled for publication in Part 1 of last year's volume; but it was not possible to print them until now.

Comment on how well or how poorly we have met our aim will be welcome. Editors of most general publications know that most readers feel they could do much better jobs if they were only the editors themselves; if some readers of THE SUPPLEMENT have similar opinions, we, as scientific editors, will not resent even sharp criticism. There are many questions involved in the revision of an editorial policy. Who are a publication's present readers? Who should naturally be its readers? We think those who

might be expected to be interested might be described broadly as all persons directly concerned, not with hospital plant, business office and upkeep, but with the care and treatment of mental patients, such as psychiatrists, nurses and student nurses, occupational therapists, physiotherapists and social workers. We know that many attendants are sincerely interested in their patients and their work and that many members of the secretarial group must give thought to the significance and interpretation of the technical material they transcribe. We hope THE SUPPLEMENT will contain articles which they will want to read also.

At present, we could answer some of our current questions better if we had some help in the answering. Are our papers in general too technical, or not technical enough, are they too wide or too narrow in range of subjects treated? Is enough or too much space devoted to this subject or that? In what ways can we make this more of an educational journal, more of a journal to increase general knowledge of accepted theories, principles and practices among all connected with our work—and among other intelligent persons interested in our work? Can we employ it usefully to further mental hygiene, prophylaxis against disorder, rather than treatment? Finally, are we going about it in the right way to keep members of our Department well-informed about developments concerning them and still produce a journal which will be primarily one of general interest, written for all workers in our field rather than solely for those in our own State service?

No editor accepts even all the undoubtedly good advice he receives. But it is important to receive it, weigh it, and then assess possibilities. Two very helpful suggestions from contributors were accepted in advance of the publication of this issue. If comments seem to the editors to warrant publication as "letters to the editor," it is planned to publish them. The directors of our institutions have had regular opportunities for open forum discussions of their problems at the Department's bi-monthly conferences; other groups have had similar open forum discussions at special or regular gatherings. But there has been no common meeting ground for our personnel in general. Perhaps there is no demand or need for one; but, if there is, and if space permits, a "letters to the editor" department might provide a place for joint discussion, by all interested, of our professional problems.

BOOK REVIEWS

Emotional Problems of Living. Avoiding the Neurotic Pattern. By O. Spurgeon English, M. D., and Gerald H. J. Pearson, M. D. 438 pages. Cloth. W. W. Norton & Company, Inc. New York. 1945. Price $5.00.

In recent years, Temple University Medical School has come to the front in leadership in the field that is now designated as psychosomatic medicine. The names of three of its professors—English, Weiss and Pearson, stand out as representative of the modern viewpoint of illness and the treatment of psychosomatic disorders—a group which has its counterpart in every medical center of importance throughout the country. These workers are coming forward with more and more evidence, based upon well-studied clinical cases, that much of the illness incapacitating individuals in every social level can be related to the influences exerted upon them in the early and formative period of life. They are teaching, and the profession is gradually learning, that what such individuals need is not medicine, or hormones, but explanation and reassurance in an atmosphere of sympathy and understanding. They are teaching, too, that many of the personality disorders are related to a failure of the emotional life to keep pace with the physical and intellectual development in adolescent years.

Individuals with stunted emotional evolution constitute not only a large proportion of the patients who haunt the consulting rooms of physicians, surgeons and specialists of all kinds (particularly gynecologists), but who also, in other phases, occupy the interest and attention of charitable and welfare boards, courts of domestic relations and courts of criminal jurisdiction. It is a large and important field which the psychosomaticists and psychiatrists are busily studying and getting into order.

The book under review is an example of this new direction of medical thought, fruitful and practical. The authors take up the life history of the individual through the several stages of emotional evolution, beginning with the oral period, followed by the anal and phallic periods and on through latency and adolescence to maturity, with lucid description and explanation. Neuroses and neurotic patterns are discussed in ample length, and the final chapter on treatment or what is to be done in the way of assistance is particularly pointed and definite. The aim is to avoid the faulty training which tends to the development of the neurotic pattern. While much space is devoted to family influences and interrelationships, little is said about heredity; the interest is directed, not to what may be fixed and

unchangeable, but to the growing personality as a plastic structure. This conception is of course one of the tenets of the psychoanalytic school of thought, and the authors pay homage to that school as offering the best approach to an understanding of human behavior.

The reviewer foresees a wide circulation for this excellent book. Its carefully thought out plan and fluent style make for easy reading and comprehension. The authors state in the preface that it was prepared not alone for the medical student and young physician but also for the clergyman, nurse, social worker and others interested in interpersonal relationships. They point out that to solve many of the difficulties besetting the clients of the social welfare worker, it is necessary for the psychiatrist, the family physician, the social worker, teacher and sometimes still others concerned to speak in language understandable to all. This is true, and it is also true that increasingly large numbers of lay and semi-professional individuals, who are seeking to understand the personality problems of themselves and of their charges, will cordially welcome this fine contribution to an understanding of the ailments they suffer in themselves or encounter in others.

Because of My Love. A Novel. By ROBERT PAUL SMITH. 185 pages. Cloth. Henry Holt and Company. New York. 1946. Price $2.50.

The author who aspires to draw upon the morbid or pathological to portray a leading character must watch his pen. He is dealing with highly explosive material. Such writing is difficult; he is dealing with the raw stuff of life; with human passions, instincts and deeply rooted unconscious motives. His story will be marked by deep shadows and even though interspersed with a few cheerful glimpses it will not always be pleasant reading.

His equipment for the task should include, besides facility in portraying the dramatic, a sound understanding of dynamic psychology. He must be well versed in modern theories of psychodynamics. A tyro will be likely to overplay the part. Something will be introduced or something will be omitted and the result will be a character out of harmony with psychological experience, awkward or grotesque to the initiated.

We do not know how the author of King Lear found his model but he must have been closely copied from life. Nor do we know about how Lady Macbeth came to be described so simply and yet so truly, or who was the paradigm for the Prince of Denmark. It is hard to believe that such characters were just imagined. One must recognize, however, that gifted poets have shown an uncanny insight which transcended the learning of the times, science plodding heavily behind the nimble feet of the poet. An example in point is Sophocles' tragedy, Oedipus Tyrannus, which moved the

ancient Greeks no less than it did Broadway audiences in recent years, and Wolfgang von Goethe has been spoken of as a predecessor of Freud.

In this short novel of present-day life in New York we become acquainted with two young people who met for the first time in a Third Avenue saloon. The red-headed girl and the serious-minded boy, each living alone, lacking the emotional anchorage of family life, became attracted to each other and the story delineates the outcome of this relationship. It portrays a psychological situation which centers in the ambivalence of love. They became acquainted in Kenny's saloon without the formality of an introduction and the interest rapidly grew into an infatuation on the part of Joe. Helen was cooler, more deliberate, in the beginning. Their marriage followed after a brief acquaintanceship. Their attempt to establish a home in a too-expensive apartment house soon involved them in financial difficulties, because neither was able to control expenditures to match income, to deny himself the enjoyment of the moment to save for more substantial comfort in the future. Too much of their joint income was spent at Kenny's at the cocktail hour, too much was spent on gifts for Helen, too much for living beyond their means in every way, and debts accumulated.

When the inevitable crash came they were saved by Helen's father with whom she had almost lost contact, whom she had rarely seen though he had a home and business in Yonkers and lived alone. He offered to share his home and business with the young people, an offer which Joe was eager to accept. When he told Helen of the offer her father had made, of partnership until he learned the business, eventually to have it for his own—"the color drained from her cheeks and she lay in his arms with her eyes gone dead and her face as white as white. She seemed half asleep, to Joe, in a dream a million miles away."

Helen is an attractive personality under congenial environment but is lacking in a sense of order or responsibility and under strain reverts to a certain immaturity like a little girl. The story of courtship and married life is told with delicacy and restraint but with sufficient detail to reveal that Joe is capable of love and is indeed deeply in love with Helen. About the latter, the reader is not so sure. There is little to indicate that ego-libido is not still dominant in her make-up and that sex does not occupy the superior rôle. Perhaps the author designed this point to be clouded, certainly the immaturity of the heroine in the psychological field is evident enough, and one may presume that such a character could not experience deep psychological love. Her narcissism relegates the entire available libido to ego libido. The effect of alcohol—and occasionly of environmental stimuli—is to diminish this cathexis, and some object-libido appears in the form of sex attraction with tenderness toward the sex object which

promptly disappears, when alcohol is the release, with returning sobriety. When Helen should experience love the emotion breaks up into its components and appears as sex attraction or as childish dependence on the love object, or else as its ambivalent counterpart. In this portrayal the author's insight and delineation are admirable.

Incident and indirection are skillfully and subtly employed to reveal the nature of the parent-child relationship; in fact, it is a question if the author has not been too subtle; even one well-versed in psychic dynamics may need to re-read to discern the groundwork for the adult aversion toward the infantile love object—which is made plain, however, in this paragraph: "She got up and took off all her clothes and went and sat by the window. The chair squeaked as she rocked, and she sang:

'Frè-re Jac-ques
Frè-re Jac-ques . . .'

The song stopped. The creaking of the chair stopped. She said to the empty room, 'When I was a little girl, he always sang this song to me. We were sitting in this very chair. He sang the song to me, and I pressed very close to him, and he stood up and threw me down and the chair stopped. I always sang this song to him. It was in this chair, and I sang the song to him, and he pressed very close to me and I stood up and threw him down and the chair stopped.' The song rose in the empty room, the chair creaked and Helen sang her song."

The book is well written, beginning in the simple, breezy style of the sporting page of the daily newspaper; slang expressions and occasional lapses into profanity in the dialogues lend emphasis that is reminiscent of Carl Sandburg, but this exuberance disappears when the story passes into another stage. When life grows more serious, the style of narrative changes too. When tragedy and impending tragedy become the themes, the style becomes serious—even austere. Here the good taste of the author is recognized. Perhaps it should be called his genius.

This book is recommended as an interesting psychological study but even more as a capital yarn. And the reviewer wonders if he has done full justice to the writing or to the skill with which the plot is developed; this tale is trimmed starkly to its theme; the reviewer has detected the omission of nothing pertinent or the inclusion of anything impertinent. And with little change of wording, this story could have been set as a poem, which one is glad it is not, although it would have been a work of art. A reviewer of a previous book by this author refers to his "clear, icy prose that sometimes warms in the sun and sings with a biblical rhythm." It is all of that; and, it might be added that, although it seems certain it was not done with artifice, a good deal of it scans.

Practical Psychology. By KARL S. BERNHARDT, M. A., Ph.D. 319 pages. Cloth. McGraw-Hill Book Company. 1945. Price $2.50.

Dr. Bernhardt is professor of psychology in the University of Toronto and is assistant director of the Institute of Child Study, Toronto. The author says in his preface that available books on psychology fall into two classes; first, those designed for college textbooks and second, those written for the general reader. The college textbooks are too difficult for many people who are not college students because they have not had the benefit of instruction by the lecturer on the topic and may lack familiarity with other related subjects which help in the understanding of the college text. The author evidently finds there is a considerable group, more studious-minded than the general reader, who may wish rather to be entertained than to learn.

In this book, Dr. Bernhardt attempts to present the subject of psychology for the serious-minded reader and home student in a book that would incorporate the accuracy and scientific viewpoint of a college textbook and yet be written in such a way that it would be understandable to readers who have not had the benefit of college classroom work. He evidently has in mind students of trade schools, technological and similar institutions of learning as well as high school students. "In writing the book the author has had in mind a particular group of readers, serious seekers after knowledge who have not had the background of university instruction. The popularity of university extension lectures in psychology has demonstrated that such a group exists."

His style is animated; he carries through the thought without becoming involved in tedious discussion. He points out that most persons have speculated upon the behavior of others generally, have wondered how it is that some find their greatest enjoyment in work while other seek to avoid it or work reluctantly. They see in themselves and each other variations in ability to learn quickly or slowly and in general terms to behave, with reference to the various problems of life, as they do. The author says that scientists are also interested in these identical problems and other similar ones but instead of merely speculating on the differences, science seeks to understand why they exist. It was in the attempt to find the answers to these and similar questions that psychology came to exist.

The book is divided into several sections and covers this subject as it is taught in the classroom in sufficient detail for the purpose intended. At the end of each chapter is an outline of the chapter and upwards of 10 review questions; and at the end of the book there is a glossary of psychological terms. The latter are briefly phrased and sufficiently explanatory;

a few such as *appetite, desire* and *feeling* hardly require definition, the latter being less readily understood than the term itself.

The book is carefully prepared, based evidently upon the author's experience as a teacher. It is a scholarly review of present-day psychology.

The reviewer would compliment the publisher on the quality of paper and typography, the sturdy binding and the general make-up of the book, which are all excellent; but he has two faults to find. The first is that the pages are numbered in the lower outside corner instead of the upper where one naturally looks for the page numbers. And some of the illustrations could be improved upon. They are evidently reproduced from photographs taken from existing texts, and not all of them are clear and sharp, in that respect being in contrast with the clearly printed pages.

Suggestion and Hypnosis Made Practical. By SAMUEL KAHN, M. D., Ph.D. 200 pages with bibliography and index. Cloth. Meador Publishing Company. Boston. 1945. Price $2.00.

This book is a review for the layman of the history, general principles and therapeutic uses of suggestion and of suggestion under hypnosis, an attempt at public education with the purpose of which this reviewer has no quarrel, and a content of which he does not propose to discuss the validity here. But this book is also a set of repeated and carefully detailed instructions in the exact technique of inducing hypnosis; precisely whom the author expects to make use of them is not clear, although he notes, of one method, that it "can be used by anyone who appears confident and acts accordingly." He does say that hypnotism for suggestion-therapy should be done by a person of good moral character who is "a capable and efficient operator, preferably a physician . . ." but he notes elsewhere: "It is important to use suggestion, auto-suggestion *and hypnosis* [Italics the reviewer's] in order to lessen the complications of life. Those who use them get along better with themselves and with others."

To test their reactions, the reviewer had several "intelligent laymen" read parts of this work and gave verbal descriptions to others; all were tempted to experiment with this fascinating phenomenon. The reviewer thinks this is psychic high explosive, that this book is exceedingly dangerous, should not be in general circulation and should not be anywhere where others than medical people can see it. He is well aware that the technique of hypnotism may easily be learned by any intelligent person from a multitude of sources ranging from books to cheap pamphlets which hordes of small boys and older gullibles order enthusiastically. But few have either the patience or the incentive to learn the technique successfully; hence, there are few amateur hypnotists, with most of them fortunately unaware that hypnotism

can be used for anything but stage or parlor tricks. Whether Dr. Kahn intended it so may be a question; but this work on hypnosis and suggestion includes strong incentives to use these methods and is itself, in general total impact, a very strong suggestion that the reader learn the hypnotic technique and employ it therapeutically. If Dr. Kahn did intend this, he is, of course, entitled to any possible belief he may hold that this would be a desirable and not dangerous development in the field of mental hygiene. This reviewer is likewise entitled to express the strongest disagreement.

The author concedes the possibility of dangers in hypnotism if operators are inexperienced or willfully abuse the method but thinks actual instances are "very rare." The reviewer thinks they will be very common if this book is widely circulated. Dr. Kahn denies the possibility that hypnotized persons—at least "normal" persons—can be forced to commit crimes by the hypnotist; this is a matter still in dispute in the technical journals; there is no fully convincing evidence one way or the other; even if it should be finally established that a "normal" person cannot be forced to commit a crime under hypnosis, how on earth can a lay hypnotist know whether a person is "normal?" The reviewer personally knows of an instance where an amnesic hysteric, hypnotized by a layman, furiously simulated a knife murder after the hypnotist had given him a motive (which doubtless reinforced an existing trend); hypnotist and reviewer agree that he would have committed a real murder just as readily. To deal with another popular belief—which Dr. Kahn does not discuss specifically and which nearly all scientific users of hypnotism question—that women may be induced under hypnotism to perform illicit sex acts, we really have no completely reliable data to support the scientific conclusion. It may be correct to hold that a woman who would not engage in illicit sex consciously would not do so unconsciously; but we cannot be certain that this reaction is universal; neither unscrupulous physician nor layman would be likely to publish a scientific paper reporting successful inducement of illicit relations; the victim would be directed to have amnesia for the experience; if this failed to be complete, almost any psychiatrist would promptly diagnose her as having a very common form of paranoid reaction. While we do question that such things can occur; we nevertheless know that love can be temporarily simulated under hypnotic direction and that sex desires can be greatly increased; we cannot find out with certainty what would happen between an unscrupulous hypnotist and a subject who did not engage in illicit sex but was physically attracted to the hypnotist; and there would appear to be no way to make controlled experiments in a matter involving medical ethics, common decency and our accepted standards of sex

morality. Even these two debatable dangers would justify keeping hypnosis therapy under accepted medical safeguards.

There are other dangers which the reviewer thinks far less debatable. Any person in need of psychotherapy manifests a disturbance of the delicate balance of powerful emotional forces. A lay "therapist," possibly not informed that those forces even exist, in any case not trained to evaluate them, might be more likely to disturb the balance still further than to correct it, if using any such powerful agency as hypnotic suggestion. There is a further and even more obvious danger. The author recounts in detail Dr. James Braid's experiments with his wife in the early days of investigation of hypnosis—the story is, in effect, a rather strong suggestion that a husband or wife would make a good subject. But hypnotism is an investigative procedure; and, although Dr. Kahn does not stress this fact, the amateur hypnotist would surely, sooner or later, discover it. One has only to imagine a somewhat jealous husband in a reasonably happy marriage hypnotizing a completely devoted wife for therapeutic purposes and then, curiosity overmastering conscience, crossexamining her as to details of her pre-marital relationships with other men. It might be difficult to devise a more potent instrument than hypnotism by a marriage partner to disrupt a marital relationship.

This reviewer agrees that more general public knowledge about the mind and its workings, including the principles and methods of hypnotism should be of benefit to general mental health; but he does not believe that hypnosis, any more than brain surgery, should on any account be "made practical." Despite long usage, hypnosis is neither a proper subject for stage entertainment nor for a parlor trick, although its use for such purposes cannot be prevented. The nature of hypnotism was long misunderstood. It is now known to be a powerful instrument by which one mind can influence or even alter, at least temporarily, the emotional or mental make-up of another person. It is capable of doing much good or of causing serious damage. It is to be regretted that knowledge of it cannot be kept altogether in medical hands; certainly we should do nothing to teach its technique to laymen. Lay psychotherapy of any sort should be done by skilled professional people under the supervision of competent medical specialists, as in the cases of social workers and occupational therapists. In the particular instance of hypnosis, experiment for non-medical purposes should be confined to trained scientific workers; hypnosis for psychotherapy should be restricted to specially trained psychiatrists or to specially trained psychologists, or others working with psychiatric advice or supervision; and we know of excellent work in hypnosis therapy by non-medical people under these circumstances.

No book which tells the layman exactly how to hypnotize and then suggests that he employ hypnotism psychotherapeutically should be "in the home of every intelligent person," as the dust jacket says this one should be. The reasoning has been given in detail because the title of the book stimulates curiosity, the author has held important medical teaching positions, and the writing is extraordinarily persuasive. But hypnosis therapy is a major psychic operation. The reviewer would as soon suggest that a layman could gain educationally by experimenting with a few appendectomies.

The New York Hospital. A History of the Psychiatric Service, 1771-1936. By WILLIAM L. RUSSELL, M. D. 556 pages. Cloth. Columbia University Press. New York. 1945. Price $7.50.

Having been established in the year 1771, the New York Hospital justly claims to be the oldest institution for the care of mental patients in New York and the second oldest in British America. It has witnessed or taken part in all the events in the history of caring for mental patients almost from the beginning and up to the present time; and its prestige and reputation were never greater than today.

Dr. Russell is admirably qualified to write this history, for he was connected with the Westchester Division of the New York Hospital as its superintendent for many years and later assumed the rôle of consultant in psychiatry for the larger unit.

Psychiatric thought and practice occupy the introductory chapters. The medical treatment of patients, as experimented with by Dr. Rush of the Pennsylvania Hospital, was studied and carried on during the earlier years. Such measures as bleeding, blisters, salivation, emetics, purges and reduced diet had their day and passed into oblivion. It is surprising, however, that some of those measures continued in active employment in general hospitals as well as in psychiatric practice for so long. A method of treatment as erroneous as repeated bleeding was esteemed in mental institutions, as it was in general practice, for many decades. It is difficult at this time, with knowledge available of the pathology of disease processes, to understand the reasoning which prompted the employment of some measures which had, long ago, extensive popularity. But then it is to be remembered that medicine was not then a science but an art, that diagnosis was largely by intuition and not by established systematic methods of investigation.

From that dark period, Dr. Russell's story takes us along through the greater developments in custodial care and medical treatment, which characterize the middle decades of the nineteenth century. From the time of

the Civil War onward, interest in psychiatry grew rapidly throughout the country. The New York Hospital had its share in these developments, and many illustrious names associated with it have made psychiatric history in America.

For many decades, when it was located in the area that later became the site of Columbia University, it was well known as *Bloomingdale Hospital*—a name dignified by its achievements and respected throughout the country. There is no doubt that the reasons for the change of title to *New York Hospital, Westchester Division* were adequate and perhaps even imperative; but to those whose memory goes back to the old days it seemed as if something had been lost when Bloomingdale Hospital ceased to be.

This well-written and interesting book is not only a history of the New York Hospital, it is more than that. It is one of the development of psychiatry in New York State, for there was a time when the New York Hospital was the only public mental hospital in the entire area of New York City and State and was—under contract with the State of New York—receiving patients who were public charges. This arrangement continued until about the time of the establishment of the New York State Asylum at Utica.

Dr. Russell's book is to be looked upon as a standard treatise on medical history.

The Examination of Reflexes. By ROBERT WARTENBERG, M. D. Foreword by Foster Kennedy, M. D. 222 pages. Cloth. The Year Book Publishers, Inc. Chicago. 1945. Price $2.50.

This author introduces his discussion of reflexes with remarks on basic principles of reflex action in general. It is evident on reflection that an authoritative work on this subject is in order, for such a work has not heretofore been published, which would give the bewildered student the understanding which he would seek on the significance of reflexes duly named and entered by enterprising investigators. Wartenberg quotes Dorland as having listed 250 reflexes, ". . . and a few more are given under the heading of 'Signs.'" He quotes a German neurologist as saying that, "Indeed, there would soon be more reflexes, especially of the lower extremities, than there are muscles and bones. A systematic synthesis would be appropriate." The author dedicates himself to such a synthesis in the volume at hand. Twenty-five reflexes are captioned and discussed—which seems to cover the human body from the orbicularis oculi to the distant toe flexor reflex.

The reviewer is made sad when the author frowns upon the patellar reflex and would have it called the quadriceps extensor phenomenon. He in-

forms us that the term is a misnomer, implying that the phenomenon has its origin in the tendon itself and not in the muscle. He includes in his disfavor patellar tendon reflex of Erb; the knee jerk of Gowers and the knee kick of various writers and lecturers. The reviewer is willing to concede that knee kick is vulnerable to criticism but knee jerk and patellar reflex are so well known and so easy to pronounce that he fears some hardy souls may still use them.

The book is carefully written and is accurate. For each reflex discussed, its method of experimental production and its significance are made plain. The volume will be found useful for advanced students of neurology. It should be in every neurological library.

The Physiology of Sex. By KENNETH WALKER. 183 pages. Paper. Penguin Books, Inc. New York. 1946. Price 25 cents.

This is the first volume this reviewer has seen of a new series, "Pelican Books," of the now ubiquitous 25-cent pulps which have introduced many Americans whose reading had been confined to newspapers and magazines to the experience of owning a book. "Pelican Books," the publishers explain, will be a non-fiction series covering subjects ranging from international affairs to science; they are patterned on a similar English series and will include many volumes written by authorities for interested laymen.

Dr. Walker's little volume was originally published as a "Pelican Book" in England in 1940. It was first published in America in 1942, though not in the "Pelican" format, and has since been reprinted seven times, the latest in October of last year. It has not come to the attention of this journal before, however, so it should be said that the author is an eminent London surgeon of wide interests within and without the field of medicine and that besides a number of technical works he has written several other books for the layman. This one was written by special invitation for the English "Pelican" series, which should interest some authors who have been complaining that the American 25-cent reprints do not give them a fair break.

"The Physiology of Sex" is a straightforward little book which any intelligent educated person should be capable of understanding. It deals with the mechanisms which determine sex at fertilization of the egg, the physiological processes associated with sex development and sex functioning through childhood, adolescence, maturity and age—and, to a lesser extent, with associated psychological and sociological phenomena. It is not an anatomy of sex and does not give instructions for intercourse; purchasers hoping for pornography will be disappointed but may gain some useful, if unanticipated, information. The principles on which this book is based are generally accepted and the treatment sound, although the psychiatrist

might might wish the author had expressed with even more emphasis than he has his opinion that most troubles in modern sex relationships are psychological, rather than physiological; and the analyst might question whether, except for cases of pathological hypo- and hypergonadism, the strength of the natural sex impulse varies as greatly from individual to individual as the author holds. But there is nothing here to lessen benefit to the general reader.

Lest the addicts of "who-dun-it" reprints, of which this reviewer is one, think this journal lacking in dignity for so ponderous a discussion of a 25-cent, paper-covered book, the reviewer will explain that he believes clinic workers, physicians and others dealing with educated and intelligent persons in need of sex information may have something here. Such a worker must now search through lists of books of conventional format which may be difficult to borrow or buy and which seem appallingly expensive to many patients if it does prove possible to buy them. If more works of this sort can be printed as cheaply as this one, it may solve an economic problem in mental hygiene. If the short "Pelican Book" list already announced (eight titles so far) is an indication, an economic problem may also be solved for the social scientist or student who would like to add more authoritative discussions to his own library but cannot afford the price in weighty, expensively bound tomes—a good text is a good text, even if newsprint between stiff paper covers is a less durable and less pretentious presentation than scientific workers are used to. Three other "Pelican Books," received later, are reviewed under the heading of "Other Publications Received" elsewhere in this issue.

Starling of the White House. As told to Thomas Sugrue by Col. Edmund W. Starling. 334 pages with index. Cloth. Simon and Schuster. New York. 1946. Price $3.00.

A *cliché* becomes such because it is an apt and reasonably accurate estimate, in terms of average mental functioning, of somebody, some function or some thing; the reviewer cannot convey the spirit of "Starling of the White House" better than by a time-honored *cliché*; that is, it is a warm, a moving and an important human document. A secret service man in the White House sees our Presidents as intimately as the members of their own families. If he is a natural psychologist as well as an official bodygard, if he likes people because they are people as well, if he is, in addition, gifted in reminiscence and anecdote, he can give us a better idea of what our chief executives have really been like than any official biographer whose concern is chiefly with deeds, not personalities. Colonel Starling seems to have been all of those things; and in writing this book, he worked with a smooth and

experienced professional novelist who seems to have been less a conventional ghost writer than a genuine collaborator, for Starling quotes much from daily letters to his mother over many years; and the rest of the phraseology is evidently genuinely his.

Starling went to the White House under Wilson; he remained a Wilson man all his life, mourned with the Wilsons over his defeat and brooded over the betrayal of his ideals. But he seems to have liked all the Presidents he served from Wilson to Roosevelt; he was unreservedly devoted to Coolidge; he seems to have been regarded as a personal friend by all of them except possibly Hoover, who, however, was as appreciative of his character and ability as any of the others.

Starling taught Wilson to ride, Coolidge to walk properly and to fish and Roosevelt to realize that as a President he must have more regard for his life. He knew Wilson, the unbending, idealistic schoolmaster as the rest of the country and the world did; but he also knew the gay and ardent Wilson in love with Mrs. Galt, the Wilson who, on his honeymoon, danced a jig and sang, "Oh you beautiful doll . . .," and the Wilson who refused in most unscholarly language but in most precise if emphatic tones an interview with a particularly obnoxious politician, "I-will-not-see-the-son-of-a-bitch."

He knew Coolidge, whose personality was misunderstood by almost the whole country, in a way almost incredible for a person who was not a New Englander. Coolidge was sentimental as well as practical; he loved fun, was a prankster, played practical jokes of the harmless type; he was in love with his wife; he enjoyed being President until his adored son Calvin died, when all the fun went out of it. Starling knew Coolidge's famous "do not choose to run" phrase was an emphatic refusal and that the President got much quiet pleasure out of the general failure to understand this typically Vermont idiom. Coolidge's own kind of people always knew most of these things; this reviewer happened, for example, to have had a first-hand report of his heart-break at the death of Calvin; and it is good to have a truer picture given to the country of this man. Starling also adds to the numberless tales of Coolidge's almost uncanny political foresight his private prediction that "that superman Hoover" would be elected and would spend money but not enough and that thereupon the Democrats would come to power and spend it like water. Coolidge died too soon to test the further prophecy that there would then be an attempt to draft him, adding, "And I won't do it."

Starling knew Harding as the rest of the country did, as a man who couldn't say, "No," to anybody. But he also knew that if he broke the Eighteenth Amendment in the White House he was a one-drink man himself. He knew that he was incorruptibly honest, that his death was natural,

that the "Ohio gang" consisted chiefly of one bribe-taker in high office from New Mexico, four others in less important posts and a number of incompetents; and that the whole scandal was distorted and magnified out of all proportions by the fact that one of the bribe-takers was also a pathological liar.

Starling saw more of Hoover's shyness, embarrassment, indecisiveness and inability to organize his administrative offices efficiently than most people saw. Starling saw Roosevelt as an optimistic American with "a four-foot yardstick," courageous and vigorous, a man he admired for persuading a skeptical, isolationist nation of its danger and getting it ready for an unavoidable war; he thinks Roosevelt got us through the depression with a minimum of scars but is less sure about this; like everybody else he felt his magnetism; and there are Roosevelt anecdotes. But Starling's heart went out of his work when Collidge died in 1933. He seems to have become Coolidge's closest personal friend; and the two men had planned, after Starling's retirement to travel and fish together. Starling didn't want to die on his job; he retired in 1943. Yet he had confidence in, and admiration for, Roosevelt, though he did not like what Sugrue, in the preface, calls his cold political sophistication—a description which some of Roosevelt's greatest admirers would consider a mild term for it. He and Sugrue were planning to collaborate on a book on Roosevelt when Starling died in 1944. It is a thousand pities, for the sake of history and many other things that it was never written.

"Starling of the White House" is less a collection of reminiscences and anecdotes than an informal study of the personalities of this nation's five Presidents from the first to the second World War. It is reported by a man whose observation was keen and whose insight was great. As such a report, it is an absorbing narrative for the student of personality structure, as well as for the student of social phenomena in general.

Other Publications

New Pelican Books. THE BIRTH AND DEATH OF THE SUN. By George Gamow. 1945. 219 pages with index and appendix, 60 figures, 16 plates. PATTERNS OF CULTURE. By Ruth Benedict. 272 pages with references and index. 1946. WHAT HAPPENED IN HISTORY. By Gordon Childe. 280 pages with index. 1946. All paper bound. Penguin Books, Inc. New York. Price 25 cents each.

These are three more volumes of the interesting new Pelican Book series mentioned in connection with Dr. Kenneth Walker's "Physiology of Sex," which is reviewed separately elsewhere in this issue because of its possible use by, or value to, clinic workers.

Professor Gamow's book is a well-known standard work for intelligent laymen, as we are likely to say patronizingly, in this case the intelligent laymen being ourselves. It was first published in 1940 and was widely read. For the reader of scientific bent who first gazed at the stars with Sir Robert Ball and then followed Sir James Jeans into the early 1930's, the body of fact since established about the universe, with the attending demolition of long-accepted theories, is rather staggering. Unlike yesterday's astronomy, it is based quite as much on subatomic research as on spectroscope and telescope. It seems rather certain, in the light of the same research which developed the atomic bomb, that the sun and the whole universe are about two billion years old; that the stars were formed before the galaxies, not the other way about; that the sun is getting hotter, not colder, and in another two billion years will almost certainly destroy all planetary life—if man hasn't done it already—by swelling into a huge "red giant" star and engulfing its satellites before shrinking to a "white dwarf" as its atomic fires fail. It is established, Professor Gamow thinks, that the energy of the sun and other main sequence stars is derived from a subatomic reaction, involving the splitting and regeneration as catalizers of nitrogen and carbon nuclei in a complicated cycle which is completed in about five million years, but which is essentially a process of transmuting hydrogen into helium. As evidence of the rate at which astronomic knowledge is being enlarged, the text of this volume, which is that of the 1940 edition, describes red giants as "young," contracting stars, while a 1945 preface reflects further research and indicates that they are greatly expanding, cooling, "aged" bodies, on the decline from main sequence brilliance. Calculating on vast increase in heat but not on such expansion, Professor Gamow had suggested in 1940 that when the sun reached maximum brilliance and the earth's seas began to boil, it might be necessary to colonize Neptune; in the light of the 1945 preface, Pluto might be still better; or perhaps scientists by then will be able to use subatomic power to rocket the earth through space to some other star, if another suitable one can be found in a universe dying for lack of hydrogen. An appendix on atomic research and the atomic bomb has been added to the original edition. It should be said that the 16 plates of this book are fine engraving on good coated stock, a surprising achievement at the price.

"Patterns of Culture" is another standard work by a recognized authority in a discipline closely related to psychiatry. Dr. Benedict is an experienced field worker in anthropology and a student of Boas. This volume, originally published in 1934, is a comparative study of the essentially noncompetitive Zuñis (Pueblo Indians), whose lives can be characterized as devoted to moderation in all things; the fiercely competitive Kwakiutl of

coastal British Columbia, with their boasting, wild excess in potlaches and strong paranoid trends; and the sorcerer-ridden Dobus of Melanesia where ill-will and treachery are socially sanctioned virtues, jealousy, suspicion and possessiveness nurtured in every family, pre-marital promiscuity sanctioned, adultery bitterly resented but committed at every possible opportunity, husbands universally spying on wives, wives commonly trying to keep husbands sexually exhausted—and all this culturally-established sex activity accompanied by a dourness and a prudery which taboos even mention of sex or of eliminative processes so effectively that Queen Victoria's court conversation might seem almost lewd. Dr. Benedict makes the point that if humanity has the capacity for such extreme diversity in cultures, no standards are fixed and eternal; we might recognize this and do something about improving our own.

Professor Childe is an outstanding archeologist and a historian. His book is not a history but is exactly what its title implies, a broad description of man and his culture, his accomplishments and failures, aims and works, from pithecanthropus erectus to the fall of the Roman empire. It presupposes some knowledge of history and perhaps could best be read with a good general history handy. To some older readers, it may recall Myers' "The Dawn of History," now unfortunately incorrect in some interpretations because of 35 years of research since Myers wrote it; but Childe writes less of personalities and less of the rise and fall of particular states or peoples than of the shifts, the changes, the developments of human cultures. He assigns much weight to economic factors and believes the Roman empire collapsed economically and was really "dead" a century and a half before the barbarians burst its borders. Any such work by any authority whomsoever necessarily makes inferences and reaches conclusions which other authorities would dispute; but this book is certainly basically sound; like Myers' it could be used for a college text. It is of interest that a book of this character could be written originally for the British Pelican series corresponding to the 25-cent American edition.

These volumes are recommended as readily accessible means of orienting or reorienting ourselves and our culture in place and time and our specialty in relation to other social sciences.

THE RESEARCH COUNCIL ON PROBLEMS OF ALCOHOL. REPORT ON STUDIES 1939-1944. A Summary for Lay Members. 23 pages. Paper. Published by the Research Council, New York, N. Y., 1945.

This brief report of the scientific investigations now being carried on by The Research Council on Problems of Alcohol, which is an associated society of The American Association for the Advancement of Science, has

come to the attention of this publication. It is intended for lay members of the council who do not have ready access to the technical publications where the scientific reports have been made. It is a summary of the work done or planned in seven survey and research projects. It is a triumph of conciseness; and it contains such an admirable statement of today's scientific attitude toward alcohol that it would be desirable if it could be more widely circulated.

REVISTA CUBANA DE NEUROLOGIA Y PSIQUIATRIA. Official publication of the Cuban Society of Neurology and Psychiatry. Dr. Esteban Valdés Castillo, president of governing board and director-founder of editorial board. Dr. Martin Castellanos M., editorial chief. Vol. 1, No. 1, February-March, 1946. Bi-Monthly. Price $.75 an issue, $3.00 a year in Cuba, $4.00 a year elsewhere.

In an introductory note on mental hygiene, which is an editorial by the director, Dr. Castillo discusses briefly the present world prevalence of feelings of insecurity and the evils which arise from wide-spread feelings of social insecurity and inferiority. He projects a mental hygiene campaign which will first seek to educate as to the existence of these feelings and their dangers, then seek to establish close connections among psychiatry, mental hygiene and teaching, finally seek to "socialize" psychological and psychotherapeutic concepts. This first number (45 pages) includes three original papers, abstracts—many from United States publications, notices and notes.

THE ALCOHOL PROBLEM. By Edward J. McGoldrick, Jr. Published by Commission on Ministerial Training, the Methodist Church, 810 Broadway, Nashville, Tenn. 1945. Price 10 cents; for 100, $5.00.

This is an eight-page reprint from the volume "Making the Gospel Effective." It is by an attorney and former alcoholic who, at the time of writing, had been director of the City of New York Bureau of Alcoholic Therapy for two years. This is an official activity of the city's Department of Welfare; it deals with alcoholics without psychoses who are referred to the bureau by various city departments or agencies. It operates on the sound scientific basis that alcoholics are ill; its treatment is psychotherapy along lines which employ both education and suggestion and appear to resemble in general those of Alcoholic Anonymous. This particular pamphlet was addressed to a religious group; and it stresses that prayer in the sense of daily positive reliance on God can help an alcoholic. But the "thought capsules" which Mr. McGoldrick presents as a "mental diet" for alcoholics in what he calls psycho-social, individual therapy, appear to

have a significant difference in their religious aspect from those of Alcoholics Anonymous, which is a non-sectarian but deeply religious organization. To be helped by Alcoholics Anonymous, one must subscribe to a fervent belief in God and His power to help one personally; seven of their 12 tenets make this explicit. The one of Mr. McGoldrick's 17 "thought capsules" which mentions religion reads, "If I pray . . ." not "When I pray . . ." There is a very large group of alcoholics in need of help who cannot accept either emotionally or intellectually the basic principles of Alcoholics Anonymous. If Mr. McGoldrick has found psychotherapeutic means to help these people, as this pamphlet suggests, his work deserves much wider attention than it has had from both psychiatrist and psychiatric social worker.

NEWS AND COMMENT

SHORTAGE OF PSYCHIATRISTS CONTINUES IN INSTITUTIONS MAINTAINED BY STATES

The shortage of psychiatrists for mental hygiene work, community clinics, public welfare, vocational rehabilitation, teaching and similar fields shows promise of relief through the return of medical officers from the armed services; but the acute shortages in many institutions maintained by the states promises to continue, according to a recent analysis presented to the National Committee for Mental Hygiene by Dr. Forrest M. Harrison, director of the Psychiatric Personnel Placement Service. Dr. Harrison did not make public figures which would allow comparison of the situations in other states with that in New York, which has just announced an attractive training program for resident physicians, as was reported elsewhere in this issue.

Dr. Harrison reported that there were only about half the openings available of the sort wanted by nearly 500 applicants; but that only 10 applicants had been willing to accept State hospital training residencies and only 19 had been willing to accept staff positions, although 430 vacancies had been registered with the service. Dr. Harrison made the general observation that the voters of each state must inform themselves on the situation and bring pressure on their legislatures to raise salaries, improve living quarters, provide training programs and raise professional standards, so as to attract younger physicians to their staffs. The Psychiatric Personnel Placement Service is a joint endeavor of The National Committee for Mental Hygiene and the American Psychiatric Association; and it places civilian physicians as well as those returning from the services.

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APPEAL MADE FOR MANILA SCIENTIFIC LIBRARY

This publication has received an appeal in behalf of the Scientific Library of the Bureau of Science in Manila for help in restoring the collection of technical and scientific works lost when the Japanese destroyed the library during the war. According to Under Secretary José S. Camus of the Department of Agriculture and Commerce of the Philippine government, it was one of the largest and best collections of technical and scientific publications in that part of the Orient. It will have to be rebuilt, he says, "from scratch;" and he is appealing for donations of any publications which can be spared. This journal wishes to do whatever can be found possible or is legally permissible; and it is passing this appeal along to readers who may

wish to make private donations. The address is: Scientific Library, Bureau of Science, Manila, Philippines.

The blows caused to science by German and Japanese invasion have been made evident in other communications. The editors have recently received an appeal from Norway and another from France. A Belgian journal seeks to resume exchange of publications including war year copies, some of which we do not have available. Any reader knowing of a collection of our own or other publications for which its owners have no present use and whose owners might be willing to make donations to foreign libraries or individual scientific workers is invited to see that it is forwarded to this journal.

A. E. BENNETT FOUNDATION IS INCORPORATED

The formation in Nebraska as a non-profit-making corporation of The A. E. Bennett Neuropsychiatric Research Foundation is announced in a small brochure, "Psychiatry and the Future." Dr. Bennett announces that the idea of the present foundation grew out of the Fever Therapy Research Department of the University of Nebraska which was carried on in conjunction with the Bishop Clarkson Memorial Hospital. As simpler methods of treatment began to replace fever therapy for many disorders, the interest of Dr. Bennett and his co-workers turned to other problems in neurology and psychiatry. Their work with curare is well known. The new foundation is intended to widen still further the field of their research work; the fundamental purpose is stated to be the achievement of specific therapies in psychiatric and neurological diseases. One aim of unusual interest to workers in psychiatry is to bring about the provision by general hospitals of facilities for accepting and treating psychiatric patients. In neurology, a project of interest is a proposal to make a completely new study of multiple sclerosis, including a world-wide survey of its incidence, with a hope of finding an approach to the problem, "preferably along entirely new lines."

CHILD PSYCHIATRY FELLOWSHIPS OFFERED

The National Committee for Mental Hygiene is offering fellowships for one or two years of training in child guidance psychiatry at centers meeting the standards of the National Association of Child Guidance Clinics. The stipends range from $2,600 to $3,000 for the first year, more for the second; prerequisites are graduation from an approved school, a general interneship and two years of general psychiatry of which at least part may have been military psychiatry.

VETERANS' ADMINISTRATION SEEKS PHYSICIANS

Like the hospitals of this and other states, the Veterans' Administration Neuropsychiatric Service is making unusual efforts to interest more qualified physicians to enter the service for training or staff positions. This publication has been requested to call attention to the program. Special training arrangements have been made with appropriate medical schools and postgraduate institutions. Salaries range from $3,300 for a veteran appointed as a resident to $9,800, with 25 per cent additional for those who have board certification.

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